

# STATE OF COLORADO

## DEPARTMENT OF HEALTH CARE POLICY & FINANCING

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Roy Romer  
Governor  
Bernard A Buescher  
Acting Executive Director

October 13, 1997

Administrator  
Health Care Financing Administration  
7500 Security Blvd.  
Baltimore, Maryland 21244

Attn: Family & Children's Health Programs Group  
Center for Medicaid and State Operations  
Mail Stop - C4-14-16

To The Administrator:

The Colorado Department of Health Care Policy and Financing (HCPF) is pleased to submit to the Health Care Financing Administration our Title XXI State Plan. We believe this plan offers an innovative and comprehensive coverage product for Colorado's uninsured children. HCPF is prepared to implement the plan on January 1, 1998, and we are excited about the opportunity to see the plan in action.

Questions about the Colorado State Plan may be directed to Michael Rothman, Director of HCPF's Office of Public and Private Initiatives. He may be reached by phone at (303) 866-3327, by page at (303) 760-7874, or by email [michael.rothman@state.co.us](mailto:michael.rothman@state.co.us). Fax communications may be transmitted to (303) 866-2803.

Sincerely,

Bernard A. Buescher  
Acting Executive Director

BAB/scp

APPLICATION FOR  
STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY  
ACT  
STATE CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory: COLORADO  
(Name of State/Territory)

As a condition for ~~receipt of Federal funds under Title~~ XXI of the Social Security Act,

\_\_\_\_\_  
(Signature of Governor or State/Territory, Date Signed)

submits the following State Child Health Plan for the State Children's Health Program and hereby agrees to administer the program in accordance with the provisions of the State Child Health Plan, the requirements of Title XXI and XIX of the Act and all applicable Federal regulations and other official issuances of the Department.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0707. The time required to complete this information collection is estimated to average 160 hours (or minutes) per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: HCFA, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, DC. 20503.

Proposed Effective Date: 1/1/98

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**Section 1. General Description and Purpose of the State Child Health Plans** (Section 2101)

The state will use funds provided under Title XXI primarily for (Check appropriate box):

- 1.1. ☒ Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (Section 2103); **OR**
- 1.2. ☐ Providing expanded benefits under the State’s Medicaid plan (Title XIX); **OR**
- 1.3. ☐ A combination of both of the above.

**Introduction**

Colorado submits its Title XXI State Plan to expand children’s access to health coverage by implementing state legislation and building on the experience and infrastructure of the Colorado Child Health Plan, a program providing basic medical services to low-income children. The Colorado Child Health Plan will adopt an expanded benefits package and additional features which will bring it into compliance with Title XXI. This Title XXI program will be called the Child Health Plan Plus (CHP+).

The Colorado General Assembly passed several pieces of legislation during the FY 97-98 session that directly affect Colorado children’s access to health care:

- House Bill 97-1304, sponsored by Representative Dave Owen and Senator Sally Hopper, authorizes the establishment of the Children’s Basic Health Plan, a subsidized health-insurance program for children ages 0 through 17 with family incomes at or below 185% of the federal poverty level. The legislation requires that the Children’s Basic Health Plan benefits be based on the Standard Plan as defined in Colorado’s small group insurance reform law (see Attachment 1 for Standard Plan benefits). Services are to be delivered through HMOs that are willing to contract with Medicaid. Premiums are to be set on a sliding fee scale. Families above 185% of poverty can buy the Children’s Basic Health Plan at full cost. The Children’s Basic Health Plan is not an entitlement. The General Assembly appropriates funds for the Children’s Basic Health Plan each year, and enrollment will be limited based on this funding.

House Bill 97-1304 also authorizes the expansion of the existing Colorado Child Health Plan from age 0 through age 12 to age 0 through age 17, and from 54 Colorado counties to all 63 Colorado counties from July 1997 until the plan sunsets on June 30, 1998. The Colorado Child Health Plan is a health care reimbursement plan for children in families with incomes below 185% of poverty. Covered services are outpatient services including primary care, specialty care, and outpatient surgery with an emphasis on preventive care and early treatment for injury and acute and chronic illness. Children currently enrolled in the Colorado Child Health Plan receive inpatient services through the Colorado Indigent Care Program. The Colorado Child Health Plan and Colorado Indigent Care

Program were intended to together deliver a comprehensive package of services to children.

The provisions of House Bill 1304: Children’s Basic Health Plan are the framework for this State Plan. We plan to initially implement the Children’s Basic Health Plan under the name Child Health Plan Plus.

- Senate Bill 97-5, sponsored by Senator Sally Hopper and Representative Dave Owen, requires that 75% of Medicaid clients be enrolled in managed care, either HMOs or the Primary Care Physician Program, by July 2000. The legislation establishes strong standards for managed care organizations to ensure quality and access including provider network adequacy, client education, performance data reporting, complaint and grievance procedures, and continuity of care. The legislation encourages contracts between managed care organizations and essential community providers and establishes a grants program for essential community providers. **An** enrollment broker will serve as the single entry into HMO enrollment to ensure clients receive objective information to make informed health plan choices. Savings realized from the growth of Medicaid managed care enrollment subsequent to June **30**, 1997 will partially fund the Children’s Basic Health Plan.
- Senate Bill 97-101, sponsored by Senator Jim Rizzuto and Representative Tony Grampsas, authorizes school districts to receive federal matching funds for money expended to provide health services through schools to children enrolled in Medicaid. Schools may use **30%** of the federal funds to provide medical services to uninsured and underinsured students.

The implementation of House Bill 1304, the Children’s Basic Health Plan, will be a collaborative process. Six design teams are currently working to: (1) determine the benefits and family cost sharing for the Children’s Basic Health Plan; (2) develop a marketing and outreach campaign and materials; (3) determine the eligibility, enrollment, and management information systems and procedures; (4) determine the procedures for tracking the flow of funds to the Children’s Basic Health Plan; (5) determine employers’ role in the expanding children’s health insurance coverage; and (6) determine the HMO contracting mechanism, rates, and performance measures. The Colorado Department of Health Care Policy and Financing will administer the Child Health Plan Plus with subcontracts **to** the Colorado Child Health Plan and the Colorado Foundation for Families and Children.

This State Plan represents the first of a two-phase approach to implementing the Children’s Basic Health Plan. This first phase begins January 1, 1998. The first phase, called Child Health Plan Plus, entails expanding the current Colorado Child Health Plan from outpatient benefits to comprehensive benefits described in Section **6.2** of this plan delivered through HMOs. The Colorado Child Health Plan provider network will serve children who live in areas of the state without HMO coverage. This comprehensive benefits package called the Child Health Plan Plus is based on the benefits and cost sharing recommendations of a

Benefits Design Team with broad-based constituency representatives (see Section 9.9 for a description of this public process). During this first phase, eligibility and enrollment systems and information management infrastructure will be built, marketing and outreach campaigns will be implemented, and identification of additional moneys for the state match will be attempted to plan for the implementation of phase two.

The second phase, called the Children’s Basic Health Plan, will include implementation of a rules-based eligibility system, a more sophisticated collections and HMO payment system, and an enhanced managed care quality oversight system. The second phase may also include a buy-in into family coverage. The overall program will be guided by the Children’s Basic Health Plan Policy Board. Colorado will submit any necessary amendments or waivers to this State Plan to implement phase two of the Children’s Basic Health Plan.

Section 2. General Background and Description of State Approach to Child Health Coverage (Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))

- 2.1. Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in section 2110(c)(2)). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements).

See Attachment 2 for a description of children’s insurance status by income and race and ethnicity.

- 2.2. Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: (Section 2102)(a)(2)

- 2.2.1: The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs (i.e. Medicaid and state-only child health insurance.)

Colorado currently has six public efforts underway to identify and enroll uncovered children who are eligible to participate in public health insurance programs or to receive public health services. These efforts are: 1) Medicaid; 2) the Colorado Child Health Plan; 3) the Health Care Program for Children with Special Needs; 4) the Colorado Indigent Care Program; 5) the Colorado Uninsurable Health Insurance Plan (CUHIP); and 6) direct health services delivered by community health centers, Title V, school-based health centers, voluntary practitioner programs, and WIC.

1. Medicaid, administered by the Colorado Department of Health Care Policy and Financing, provides health coverage to low-income, elderly and disabled Coloradans. Colorado takes the following steps to enroll children in Medicaid:
  1. County social services departments determine a person’s eligibility for TANF and Medicaid. Presumptive eligibility sites (Federally Qualified Health Centers and Planned Parenthood clinics), county nurses’ offices, doctors’ offices and Indian Health Centers determine Medicaid eligibility and enroll pregnant women. Infants up to twelve months old born to Medicaid-enrolled women are guaranteed Medicaid eligibility for twelve months.
  2. Outstationed eligibility sites (FQHCs, Disproportionate Share Hospitals, and local county health departments) help people apply for Medicaid by collecting and sending their applications and paperwork to the county social services office for eligibility determination.

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Proposed Effective Date: 1/1/98

3. Posters, brochures, and a 1-800 number provide Medicaid information to potentially eligible families at several locations, including public assistance offices.
  4. The Colorado Child Health Plan refers applicants who are eligible for Medicaid to their county social services office.
2. The Colorado Child Health Plan (CCHP), administered through the University of Colorado Health Sciences Center, is legislatively established as a community-based health care reimbursement plan for low-income children under the age of eighteen. The plan provides outpatient medical care to children from families whose incomes place them at or below 185% of the Federal Poverty Level. Children eligible for Medicaid are not eligible for the Colorado Child Health Plan. Colorado Child Health Plan applicants who appear to be eligible for Medicaid, from income and asset data provided on the family's CCHP application, receive a letter from CCHP referring them to their county social services department to apply for Medicaid. Colorado Child Health Plan providers must accept their CCHP patient as a Colorado Medicaid patient if that child switches from CCHP to Medicaid during the contract year. (Please see Section 2.2.2 for more information on the Colorado Child Health Plan.)
3. The Health Care Program for Children with Special Needs (HCP) is a joint state/federal program administered by the Colorado Department of Public Health and Environment for children age 20 and under who have a physical disability that interferes with normal growth and development. HCP helps pay medical bills and provides follow-up for children diagnosed with a clinically qualifying handicapping condition. Children with conditions eligible for the program are identified through county nursing services, health care providers, Child Find coordinators in public schools, and local Early Childhood Connections staff. Currently, about 5,000 children are enrolled in HCP statewide.

Public health nurses and discipline coordinators in nutrition, speech, audiology, deafness, occupation/physical therapy and social work also provide care coordination across agencies by assuring that services in the schools and through Community Centered Boards are not duplicative of those provided in medical settings. HCP coordinates benefits with public and private health insurance programs to assure coverage for needed services that are not covered under a particular plan. Through coordination of benefits between HCP and Medicaid, HCP pays only for covered services not paid by Medicaid. Through coordination of benefits between HCP and CCHP, HCP pays for services related to the disability, and CCHP pays for all other CCHP-covered health care.

Applicants deemed eligible for HCP are enrolled at regional HCP offices. Based on income data provided on their HCP application, those who appear to be eligible for Medicaid are required to go to their county social services office to apply for Medicaid, and to report back to HCP if qualified for Medicaid. HCP-enrolled children and their siblings who are not eligible for Medicaid are automatically eligible for the Colorado Child Health Plan, and can enroll on a short application form, through a facilitated application agreement between CCHP and HCP administrations. HCP coordinators and regional offices have CCHP short enrollment forms and help families enroll in CCHP.

- 4. The Colorado Indigent Care Program (CICP), administered by the Colorado Department of Health Care Policy and Financing, is a state and federally funded provider reimbursement program that discounts the cost of medical care at its participating health facilities for adults as well as children. If a person is eligible for Medicaid, he or she is ineligible for CICP. Covered services vary by participating hospitals or clinics, but generally include hospital costs such as inpatient stays, surgery, and prescription drugs. All children deemed eligible for the heretofore mentioned programs are directed toward them at CICP-participating providers. Colorado takes the following steps to enroll children in the Colorado Indigent Care Program (CICP):
  - CICP-contracted providers (primarily FQHCs, DSH hospitals, and participating clinics) screen children for CICP eligibility during their visit, assist with completing the application, and determine eligibility for the program.
  - The non-CICP community health centers and other safety net providers who determine Medicaid eligibility refer clients to a CICP provider if they determine that a client is not eligible for Medicaid, but may be eligible for CICP.
- 5. The Colorado Uninsurable Health Insurance Plan (CUHIP), established in **1990** by the Colorado General Assembly as a quasi-governmental entity, provides health insurance to individuals, including children, who are denied health insurance by private carriers because of a pre-existing medical condition. People who are eligible for Medicaid or Medicare cannot enroll in this program. Only eight people, or one percent of those CUHIP members who disenrolled from the plan in **1996**, did so because they became eligible for Medicaid.
- 6. Direct health services are provided by community health centers, county public health departments, school-based health centers and voluntary practitioner programs.

- Community health centers offer a wide range of health care to people who may need some financial assistance with their medical bills. Colorado has 15 community health centers with more than 50 clinic sites in medically under-served areas of the state. Community health centers provide comprehensive primary care services including care for acute and chronic illness, injuries, family planning and prenatal care, emergency care, diagnostics services and prescriptions.

Community Health Centers take the following steps to enroll children in Medicaid, the Colorado Indigent Care Program, the Colorado Child Health Plan, or the health center's sliding fee scale plan:

1. Provide a financial screen for each new patient or family.
2. Provide information on and explanation of the program(s) that the family members are eligible for.
3. Assist with completing applications and collecting required documentation.
4. Determine eligibility on-site or forward applications to the determining agency and communicate with family about eligibility status.
5. Assist families when their financial situation and eligibility changes to switch to the appropriate program.

If a patient/family is not eligible for any program, the health center uses its sliding fee scale to determine the fee according to family size and income.

- Maternal and Child Health Block Grant (Title V of the Social Security Act) funds in Colorado are "passed through" to local public health agencies and other qualified non-profit agencies where they are used to support a number of activities on behalf of woman and children, particularly those of low income. State Title V staff provide oversight, consultation and standards to assure appropriate utilization of these funds. When families are ineligible for any insurance plan, or when there is not another provider of free or reduced price health care (i.e. community or rural health centers) available or accessible, these public health agencies provide direct services to low income children. Services provided in local public health agencies are almost always provided by public health nurses. Services include comprehensive well child clinic services, including developmental and physical assessments, immunizations, and parent education. Families under 100% FPL pay nothing for these services. Others pay on a sliding fee scale.

Local public health agencies identify low income, uninsured children through referrals from a variety of sources including: WIC, child health and immunization clinics, other community health providers (including private physicians), community health and social services agencies and schools, Headstart centers, Early Childhood Connections (Part C), homeless shelters, and self-referrals. Public health staff will refer families to any available health care insurance source for which they appear to be eligible, including Medicaid and the Colorado Child Health Plan, and will often work with local physicians to ~~try~~ and secure services on a reduced-fee basis. Many public health agency staff will assist families in completing application forms for Medicaid or the CCHP. In Colorado, Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT) outreach workers and administrative case managers are a part of local public health agency staff who facilitate access to Medicaid and to Medicaid services for eligible children. Funding for local EPSDT outreach staff comes to the state Title V agency from the state Medicaid agency and is distributed locally through the Colorado Department of Public Health and Environment (CDPHE). CDHPE also oversees Title V funds going to those same agencies for public health and child health services.

- School-based health centers provide comprehensive primary care services including care for acute and chronic illness, injuries, family planning and prenatal care, some diagnostics services and prescriptions. SBHCs provide services at no charge. However, patients are asked whether they have health care coverage. The degree to which the SBHCs bill for reimbursement depends on the administrative capabilities of the center. **SBHCs** facilitate application to Medicaid, CCHP or CICP when documentation of family income and assets is obtainable without jeopardizing students' confidentiality.
- The **Special** Nutritional Program for Women, Infants and Children (WIC) provides nutritious food to supplement the regular diet of pregnant women, breast-feeding women, infants, and children under age five who meet state income standards. Women and children under five years old qualify if the combined family income is at or below **185%** of the federal poverty level. WIC staff encourage pregnant women and parents and guardians of infants under 12 months of age to apply for Medicaid. At community health centers, these women and children qualify for presumptive eligibility in Medicaid and receive immediate care. WIC staff distribute application forms for the Colorado Child Health Plan.

Children enrolled in WIC who are not eligible for Medicaid can enroll in CCHP on a short enrollment form through an information sharing agreement between WIC and CCHP.

- The Commodity Supplemental Food Program (CSFP) provides infant formula and nutritious foods to supplement the diet of pregnant and postpartum women and children under age 6. Women who live in Conejos, Costillo, Denver, Mesa, Rio Grande or Weld counties and who have a combined family income at or below 185% of the federal poverty level qualify for the program. CSFP distributes short application forms for the Colorado Child Health Plan.

**2.2.2. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership:**

Colorado currently has three public efforts underway to identify and enroll uncovered children who are eligible to participate in health insurance programs or to receive health services that involve a public-private partnership. These efforts are: 1) the Colorado Child Health Plan, 2) the Kaiser School Connections Program, and 3) voluntary practitioner programs.

1. As mentioned above, the Colorado Child Health Plan (CCHP) is a health insurance program for children 17 and under with family income at or below 185% FPL. The CCHP covers outpatient services including preventive and primary care, specialty care, emergency care, diagnostics and prescriptions. The CCHP has been established through a broad community coalition including generous support from Blue Cross Blue Shield of Colorado and the University of Colorado Health Sciences Center, among others.

The outreach coordinator at the Colorado Child Health Plan works actively to recruit social service workers, county commissioners, physicians and physicians groups, hospital administrators, family resource centers, school nurses, public health nurses and school district representatives to hold community forums where information about the CCHP is widely distributed. In 1997, eight such community forums were held throughout the state with widespread community participation. These representatives throughout the state act as advocates for children to enroll them into the program. Families enroll their children on a mail-in application available by calling a toll-free telephone number. Furthermore, children who want to enroll in the Colorado Child Health Plan and are determined to be eligible for Medicaid (and therefore ineligible for CCHP), are redirected to their county social service agencies and are strongly encouraged to apply for Medicaid coverage.

Colorado takes the following steps to enroll children in the Colorado Child Health Plan:

- Outreach and application assistance is available at contracted health care provider offices (including FQHCs, DSH hospitals, local county health departments, and private providers).
  - A primary vehicle for identification and enrollment of children is on-going cooperation with local school districts to market the program. Children eligible for the Free and Reduced Price Meals programs, the Special Nutritional Program for Women Infants and Children (WIC) program and the Health Care Program for Children with Special Needs (HCP) have a shortened application form and facilitated application process. Children who are not already receiving public assistance through these particular programs can apply for the CCHP on a longer application form.
  - Outreach through posters, brochures, presentations, public service announcements, and television ads target audiences of potentially eligible families and children.
2. Kaiser Permanente offers the School Connections program, a new health care plan for low-income uninsured school children, introduced in January **1997**. School Connections is the first program in the nation to offer full comprehensive health care services in collaboration with school-based health centers. The program enables **1,300** children to receive full Kaiser Permanente benefits for **\$3** a month. Preventive services are provided at the school-based health center and Kaiser Permanente provides the rest. Services include primary care, mental health, chemical dependency, laboratory, x-rays, emergency care, specialty care, and outpatient and inpatient hospital care.

School Connections **is** a collaborative two-year pilot program that is estimated to cost \$1 million annually. School Connections is available through twenty Denver, Adams County District **14** and Sheridan public schools. If a child is eligible for the Free and Reduced Price Meals Program, the child is eligible for School Connections. Children can enroll on a first-come-first-served basis if they are attending one of the selected schools. The creation of the School Connections program has been the result of a public-private partnership with the Colorado Department of Public Health and Environment, the Colorado Department of Health Care Policy and Financing, school-based health centers and Kaiser Permanente. Enrollment for the program has been successfully achieved through cooperation between the participating school districts and Kaiser Permanente.

3. Voluntary practitioner programs include The Children's Clinic in Fort Collins, The Monfort Clinic in Greeley, Doctors Care in Littleton, Rocky Mountain Youth in Denver, and the Marillac Clinic in Grand Junction. Doctors Care operates a primary

care clinic staffed by nurse practitioners. The program refers patients who need specialty care to members of the Arapahoe Independent Practice Association, who provide free care. Rocky Mountain Youth, a Denver not-for-profit, provides health care services to low-income and homeless children. The group also aids practitioners in understaffed rural communities and staffs a mobile health van. In 1996 the organization treated 10,000 children. Five doctors, three nurse practitioners and a social worker provide health care on a sliding fee scale with reimbursement from Medicaid, client cost sharing, and donations from the community. The Marillac Clinic in Grand Junction is staffed by volunteer physicians and nurses, and provides free care to individuals who have no coverage of any kind. These programs advertise through school districts, county health departments, doctors' offices, and hospitals.

**23 Describe how the new State Title XXI program(s) is(are) designed to be coordinated with such efforts to increase the number of children with creditable health coverage so that only eligible targeted low-income children are covered:**  
(Section 2102)(a)(3)

Current Colorado Child Health Plan members will have a choice of staying in the outpatient CCHP or enrolling in the Child Health Plan Plus (CHP+) to receive a comprehensive benefits package. These members will receive materials informing them of their choice and the process for enrolling in the CHP+. See Section 5 for a description of the outreach methods to current CCHP members. Children applying to the CHP+ on or after January 1, 1998 will not have the CCHP outpatient option and must choose the comprehensive CHP+ benefits package.

The state plans to coordinate its program eligibility and HMO enrollment efforts for the CHP+ with community health centers, CICP providers, Medicaid, and public health outreach nurses. These providers will either help determine CHP+ eligibility (through a rules-based eligibility system available on an Internet Web site or through paper applications faxed or mailed to the CHP+ administrative offices) or will refer people to the CHP+ toll-free telephone line for eligibility determination. CHP+ will pursue cooperative agreements with interested county social service offices to exchange CHP+ and Medicaid application information. Families who apply for Medicaid will be informed about the CHP+, and families applying for CHP+ will be informed about Medicaid. Medicaid applicants with children who do not qualify for Medicaid will be asked to sign a release form permitting the information provided for their Medicaid application to be used to determine the children's eligibility for the CHP+. Likewise, CHP+ applicants found to be Medicaid eligible will be asked to sign a release permitting the information provided for their CHP+ application to be used to determine the child's eligibility for Medicaid.

The Child Health Plan Plus will undertake a two-phase approach to ensure that Medicaid-eligible children are enrolled in Medicaid. The first phase will entail summary screening of CHP+ applicants for Medicaid eligibility and referral of children likely to be Medicaid-eligible to county social service offices, as well as utilization of Medicaid

outstationed eligibility and presumptive eligibility providers to determine CHP+ and Medicaid eligibility. The second phase will entail implementation of an integrated eligibility system for medical assistance programs including the CHP+ and Medicaid.

Phase One: The Child Health Plan Plus Eligibility System

From the date of state plan implementation until June 2000 when the Colorado Benefits Management System (see Section 2.3) is operational, CHP+ will collect family income, family size, and family asset information that will enable the eligibility technician to determine if the applicant is likely to be eligible for Medicaid. If the child appears to be eligible for Medicaid, the family will receive a letter informing them to contact their county social services office and will be given a 1-800 number if they have further questions. Information may be shared between CHP+ and county social services offices as described above.

Families who apply for the CHP+ at community health centers and other safety net providers who are Medicaid outstationed eligibility and/or presumptive eligibility sites can either receive assistance in applying for Medicaid or be presumptively enrolled in Medicaid if they are pregnant women or infants under one born to women enrolled in Medicaid. These Medicaid outstationed eligibility providers and presumptive eligibility sites will serve as Satellite Eligibility Determination Sites (SEDS) for the CHP+. This will assure coordination of Medicaid and CHP+ eligibility determination by allowing the same entities to determine or assist in determining eligibility for both programs. A family who applies for Medicaid at the county social services office and is found ineligible will be able to apply for the Child Health Plan Plus.

Phase Two: Colorado Benefits Management System (CBMS)

The second phase of coordinated Medicaid and Child Health Plan Plus eligibility determination requires the development of an integrated eligibility system. This information system, the Colorado Benefits Management System (CBMS), is a joint development effort between the Colorado Department of Human Services and the Colorado Department of Health Care Policy and Financing. Beginning in July 2000, providers, families, and public agencies will be able to determine eligibility for a range of public medical assistance programs through the CBMS. The CBMS will allow families who apply for the CHP+ but are determined to be Medicaid eligible to automatically enroll in Medicaid. The CHP+ will pilot this rules-based eligibility system during phase one. Systems and rules developed through this CHP+ eligibility system will be incorporated into the CBMS upon its implementation.

The state plans to use an enrollment broker for the Medicaid managed care program to enroll Medicaid clients into HMOs. The enrollment broker will help Medicaid clients who call to find a managed care option that works best for them. The Medicaid enrollment broker contract is estimated to begin January 1998. The RFP for the enrollment broker asked bidders to include an enrollment function for the CHP+ as well

as to estimate the additional cost of conducting eligibility determination for the CHP+. An enrollment broker with responsibility for the Medicaid and CHP+ programs would help families select providers to ensure continuity of care if they move between the two programs. CHP+ applicants will either choose an HMO at the time of eligibility determination, or choose an HMO within 14 to 45 days. The latter group will be referred to the enrollment broker for information on health plan choice and HMO enrollment services based on CHP+ enrollment protocols. The state will continue to explore the possibility of using the Medicaid enrollment broker for the CHP+ based on consideration of bids submitted in October 1997.

**Section 3. General Contents of State Child Health Plan (Section 2102)(a)(4))**

☐

**Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 4.**

**3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children: (Section 2102)(a)(4))**

Delivery of health services to Child Health Plan Plus members will be primarily through Health Maintenance Organizations (HMOs.) The outpatient Colorado Child Health Plan currently maintains its own statewide provider network. This network will be expanded to care for children who are eligible for CHP+ but who have not yet been enrolled in an HMO (HMOs generally initiate coverage on the first of the month only), or those children who live in areas where no HMO service is available.

**HMOs**

While over 20 HMOs are licensed to do business in Colorado, state legislation (House Bill 97-1304) requires that only plans willing to contract with Medicaid are eligible to serve CHP+ clients. This will insure that clients are not forced to change providers each time their financial situation changes the program for which they are eligible. Currently, seven HMOs contract with the Colorado Medicaid program: Kaiser Permanente, Rocky Mountain HMO, Colorado Access, QualMed, Community Health Plan of the Rockies, United HealthCare, HMO Colorado. These plans vary in structure, service area and membership. For example, Kaiser Permanente operates in the Denver metropolitan area and has over 300,000 commercial members. Rocky Mountain HMO serves significant numbers of commercial and Medicaid clients statewide. Colorado Access serves exclusively Medicaid members in metropolitan areas throughout the state using community health centers and public hospitals for service delivery.

HMO contract standards and premiums will be developed in collaboration with the Children's Basic Health Plan design teams. (See Section 9.9 for a description of the process to involve the public in design of the plan.) The CHP+ HMO contract will address the following areas: enrollment, marketing, benefits, premiums, provider network, utilization management, quality of care, access to care, member rights, and grievance procedures. Contract standards will be based on a review of standards from the following sources: National Association of Insurance Commissioners (NAIC) Model Acts, National Committee for Quality Assurance (NCQA) Accreditation Standards, Quality Improvement System for Managed Care (QISMC) standards, and commercial HMO contracts in Colorado (if available) such as The Alliance (a small group purchasing cooperative) and The Colorado Business Group on Health (a large employer coalition). Final contract provisions will be negotiated through the Contracting and Quality Assurance Team composed of consumers, plans, state agencies, and provider organizations.

A potential CHP+ HMO contractor will have to pass the examination of three entities: the Colorado Division of Insurance (DOI), the Department of Public Health and Environment (CDPHE) and the Colorado Department of Health Care Policy and Financing (HCPF). The DOI grants HMO licenses based on a review of financial stability, adequate provider subcontracts, access to care and quality of care. The DOI subcontracts the quality and access review to the CDPHE. When a licensed plan applies for a Medicaid contract, HCPF reviews several aspects of the plan's operation including provider network, utilization, management, access to care, quality improvement and grievance procedures. HCPF will further review a Medicaid plan who applies to serve CHP+ clients. Where CHP+ contract standards vary from those of DOI and HCPF, the Department will conduct additional reviews in coordination with the Medicaid, DOI, CDPHE, or other purchaser reviews. For example, an appropriate CHP+ network would include an adequate number of pediatricians and pediatric specialists within a reasonable distance of potential enrollees.

Project staff plan to have executed contracts with participating CHP+ HMOs on January 1, 1998.

#### Child Health Plan Plus Provider Network

The existing Colorado Child Health Plan has developed its own statewide provider network. These physicians, hospitals and ancillary service providers will deliver the Child Health Plan Plus comprehensive benefit package described in Section 6.2 in areas where HMO services are not available. The Department of Health Care Policy and Financing hopes that areas of the state without HMO coverage will be very few if any. In its provider network program, the CHP+ will reimburse its primary care physicians under capitation and will reimburse its specialty, inpatient, and pharmaceutical providers on a fee-for-service basis. Blue Cross Blue Shield of Colorado will continue to donate the plan's fee-for-service claims processing services. Pharmacies accepting the PCS Health Systems plan will continue to provide prescription benefits.

**Primary Care:** CHP+ will use the Colorado Child Health Plan physician network that currently includes over 1,000 participating primary care providers to provide routine care and case management. Primary care providers receive a monthly capitation payment. For members whose utilization of care is significantly greater than the norm, the CHP+ will, upon review by plan's medical director, either supplement the capitation with a case management fee, or pay the lesser of billed charges or the CHP+ maximum reimbursement minus the copayment instead of the normal monthly capitation.

**Immunizations:** Like the Colorado Child Health Plan, the CHP+ will aggressively encourage appropriate immunizations for its members. The Colorado Department of Public Health and Environment supplies CCHP providers with free vaccine under the Vaccines for Children Program. CCHP now pays its providers \$10 per dose as an administration fee.

**Specialty Care:** As with the Colorado Child Health Plan, primary care providers will refer CHP+ members to any one of over 1,500 participating specialists for medically necessary specialty care.

**Hospital Benefits:** As the Colorado Child Health Plan ~~Was~~ done for non-inpatient hospital benefits, the CHP+ will pay for all hospital benefits fee-for-service at the Colorado Medicaid rate. The plan has already signed contracts with 57 hospitals throughout the state. These contracts are being amended to include inpatient care.

**Pharmaceuticals:** Like the Colorado Child Health Plan, the CHP+ pharmaceutical benefit will be available to members through the HMO Colorado pharmacy network. This affiliation allows the plan to process claims through the online PCS Health Systems plan. All pharmacies contracted with PCS are able to accept CCHP member prescriptions and will be able to accept CHP+ member prescriptions. The majority of Colorado's pharmacies belong to the PCS network.

For the purposes of procuring medical providers, the Colorado Child Health Plan maintains contractual agreements with primary care providers, specialists, ancillary care services, hospitals and provider networks throughout the State. These contracts will be extended with modifications necessary to implement CHP+ .

**3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children: (Section 2102)(a)(4)**

HMOs and providers who contract with the Child Health Plan Plus program will primarily perform utilization management functions. Utilization management functions for the CHP+ provider network will be split between contracting providers and the Child Health Plan Plus. Health maintenance organizations, on the other hand, will have a full delegation of all utilization management functions.

**HMO Utilization Controls**

CHP+ contract standards **will** require a participating HMO **to** have adequate utilization management staff and procedures to assure that services provided to enrollees are medically necessary and appropriate. The utilization management contract standards will address the contractors written program, procedures, staff, timelines, and denials. Project staff will review the NAIC, NCQA, and QISMC guidelines referenced in Section 3.1 for development of these standards, but will also ensure that the standards are consistent with Colorado Division of Insurance regulation requirements.

Monitoring HMO compliance with utilization management contract standards will be accomplished in one of three ways: 1) the plan will show current NCQA accreditation (only two of the seven eligible plans now have this status); 2) CHP+ program staff will coordinate with Medicaid annual on-site review; or 3) CHP+ will contract with an

external review entity to evaluate plan contract compliance. Project staff will evaluate the appropriate mechanism to review non-NCQA-accredited plans, based on factors such as effectiveness and cost.

**Fee for Service Network Utilization Controls**

The Child Health Plan Plus will use utilization control methods currently employed by the Colorado Child Health Plan: primary care providers, referrals, prior authorizations, and educational services.

**Primary Care Providers (PCPs)**

The Colorado Child Health Plan depends upon its PCPs to tightly manage member care. The child's PCP is the first person the child sees when she is sick or needs preventive care (except when visiting a participating OB/GYN physician for an annual gynecological exam). The primary care provider's office should be easy for the child to travel to and easy to reach by telephone at all times.

The PCP performs all routine non-emergency care for the child and services that are usually done periodically within a specific time frame (e.g., immunizations or physical exams). Routine care is performed during the PCP's normal business hours. When the child visits his or her primary care provider, the child can see any of the participating health care professionals in that practice including MDs, DOs, nurse practitioners, child health associates, and physician's assistants.

The PCP makes all necessary arrangements for the child's care. The PCP will refer the child to a hospital or specialists when needed. A referral must be issued from the primary care provider before the child receives services from a specialty provider or facility. This referral must be entered into the plan's system and a referral number must be generated before the referred service claim will be reimbursed.

The child may change PCPs at the time of renewal and only once without cause during the enrollment year. Exceptions to this policy may be made for a change of residence and on appeal. The appeal must be documented explaining the reason for the change request.

**Referrals**

The PCP will obtain a referral number from the plan's third party administrator by phone or Will fax the referral information to the plan's third party administrator. Blue Cross Blue Shield of Colorado will continue to donate these third party administration services. The plan will mail a confirmation referral form or a denial of the referral request to the member, the PCP, and the specialist. For in-network referrals, confirmation or denial will be given over the phone or within 24 hours by Fax.

The referral letter indicates the number of visits approved and the time period in which the member must receive care. If only one visit is authorized, a second visit will not be covered. The family is responsible to pay for all visits in excess of those authorized and for care received before or after the specified time period.

A referral is not required for a child to visit a participating OB/GYN provider for an annual routine gynecological exam. To visit an OB/GYN provider without a referral, the member must choose an OB/GYN provider within the plan network; otherwise, coverage will be denied. To visit an OB/GYN provider outside of the plan network, a referral to a non-participating provider must be obtained.

Prior Authorizations

Prior authorizations from the plan are required before a member can receive certain services or services outside of the plan’s network. The child’s PCP is responsible for obtaining all necessary prior authorizations. Services requiring prior authorizations include, but are not limited to:

- All outpatient therapies including physical therapy, speech therapy, and occupational therapy
  - Services performed by a provider outside the plan’s network
  - Elective hospital admissions
- Home health care
- Hospicecare
  - Inpatient and outpatient surgery
- Durable medical equipment
  - Some diagnostic tests
- Some prescriptions

A complete list of services requiring prior authorization is available to providers in the CHP+ Provider Manual.

Educational Services

The plan provides families, health care providers and human services workers with education about the plan and how to use the plan. This includes quarterly newsletters about new policies, common problems and frequently asked questions; a Benefits Booklet; and a Provider Manual. Customer service representatives are available to answer questions.

Section 4. Eligibility Standards and Methodology. (Section 2102(b))

☐ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 5.

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. (Section 2102(b)(1)(A))

4.1.1. ☐ Geographic area served by the Plan: The plan is available statewide, in all 63 Colorado counties.

4.1.2. ☐ Age: The plan is available to children 0 through 17 years of age. This age criteria allows a family to apply for one full year's coverage up to the day before the child's 18<sup>th</sup> birthday. That child will then receive 12 months coverage through the day before that child's 19<sup>th</sup> birthday. The family must prove the child's birth date by submitting a birth certificate, a hospital record or a baptismal record.

4.1.3. ☐ Income: Eligible children are from families whose incomes are at or below 185% of the federal poverty level. Children seeking coverage under the Child Health Plan Plus cannot be eligible for Medicaid. See Attachment 3 for a description of the family size and income criteria.

4.1.4. ☐ Resources (including any standards relating to spend downs and disposition of resources): The net asset value of family resources in excess of disallows in four categories is added to income when determining a family's financial eligibility. These asset values do not have to be documented. Technicians rely upon a family's self-reported net asset values. The value of assets in excess of the disallows are counted as income. There is no requirement that assets be less than a certain amount for a person to be eligible for the CHP+. See Attachment 4 for a description of the Colorado Child Health Plan resource verification criteria that will be used by the CHP+. The plan will allow spend downs for medical bills, day care, and child support. These are detailed in Attachment 4.

- 4.1.5. ☒ **Residency:** Colorado residency is required. A resident is anyone who is: 1) a **U.S.** citizen; or 2) a documented immigrant; or 3) a Colorado resident; or 4) a migrant worker. See Attachment 5 for a description of the residency verification criteria.
- 4.1.6. ☐ **Disability Status (so long as any standard relating to disability status does not restrict eligibility):** No child is denied eligibility based on disability status. If the child receives **SSI** and is eligible for Medicaid, the child will be denied coverage because she is eligible for Medicaid, not for reasons of disability status.
- 4.1.7. ☒ **Access to or coverage under other health coverage:** Both the application and the separate “Insurance Form” ask families questions about other insurance coverage. The plan administration seeks information about all other access to health care coverage, both public and private, on the application form before the child is enrolled in the plan and from providers once the child is enrolled in the plan. A child will be found ineligible if: 1) she is covered under a group health plan or under health insurance coverage as defined in section 2791 of the Public Health Service Act; or 2) she is eligible for Medicaid; or 3) she is a member of a family that is eligible for health benefits coverage under a State health benefits plan based on a family members’ employment with a public agency in the State; or 4) she has had coverage under an employer plan with at least a 50% employer contribution during the past three months.
- 4.1.8. ☒ **Duration of eligibility :** Once a child has been accepted, he or she is continuously eligible for one year from the date of the application or HMO enrollment unless the child moves from the state or becomes enrolled in Medicaid.
- 4.1.9. ☐ **Other standards (identify and describe):**

**4.2.** The state assures that it has made the following findings with respect to the eligibility standards in its plan: **(Section 2102)(b)(1)(B))**

- 4.2.1.** ☒ These standards do not discriminate on the basis of diagnosis.
- 4.2.2.** ☒ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.
- 4.2.3.** ☒ These standards do not deny eligibility based on a child having a pre-existing medical condition.

**4.3.** Describe the methods of establishing eligibility and continuing enrollment.  
**(Section 2102)(b)(2))**

Both initial eligibility and annual renewal eligibility for the Child Health Plan Plus will be determined either at the main office or at a decentralized eligibility site. All applications will be received by mail or by Fax at the central office or during face-to-face interviews at the decentralized sites.

The CCHP administration uses one of four methods for determining an applicant's income to establish current financial status. The following Colorado Child Health Plan methods of establishing eligibility and continuing enrollment will be applied to the Child Health Plan Plus. The methods are:

- Method I: Current employment income and cash from other sources reported on a full application is used to qualify families with employment or retirement income.
- Method II: The current monthly expenses method is used for self-employed and unemployed applicants. These monthly expenses are reported on a full application.
- Method III: For unemployed applicants who cannot document monthly expenses, and for seasonal workers who have indicated uneven employment in the "Income Exceptions" portion of the application, the plan administration uses the most recently filed income tax return. The income tax return is enclosed with the family's full application.
- Method IV: For children whose families are enrolled in any one of six other state assistance programs, the CHP+ will enroll these Medicaid-ineligible children in the plan using "easy enrollment" procedures. Application for the CHP+ thus can be made on one of three short applications. Verification of income reported on short forms is obtained directly

from the plan's sister agencies. This income verification determines both program eligibility and family cost-sharing requirements.

- 1) The yellow short form is made available to families who have enrolled in the Colorado Indigent Care Program (CICP) through one of the state's "safety net" providers. Since the eligibility guidelines for the CHP+ are identical to those used by the CICP, children enrolled using this short application immediately receive the same letter rating as that assigned to the family at the decentralized eligibility site for the CICP.
- 2) The green short form is made available to families with at least one child enrolled in the state's Free and Reduced-Price Meals Program. Children who receive Reduced-Price Meals are automatically eligible for the CHP+ because their families' income is, by definition, between 130% and **185%** of the Federal Poverty Level. Children who receive Free Meals are screened for Medicaid eligibility before they are enrolled in the CHP+.
- 3) The purple short form is made available to families with at least one family member enrolled in either the Commodity Supplemental Foods Program, the Special Nutritional Program for Women, Infants and Children, or the Health Care Program for Children With Special Needs. Each of these programs has a family income ceiling of **185%** of the Federal Poverty Level. In each case, applying children are screened for Medicaid eligibility before they are enrolled in the CHP+.

#### Information Systems Support for Eligibility Determination and Capitation Payments

All paper **flow** into and out of the plan offices will be tracked on the networked database currently used by Colorado Child Health Plan. This information system contains a rules-based rating system, a fully automated capitation payments system, and a series of tracking records which mirror the handling of paper membership applications from the moment they are received by mail, Fax, **or** personal contact, to the moment that the completed application is filed and the family receives its Benefit Packet and health plan cards.

Application and member tracking within the CHP+ information system includes five major functions: the determination of patient-file status, application processing, eligibility determination, enrollment, and the storage of enrollment data for active patients. The majority of applicant data is stored in five primary tables: file tracking, application, family information and patient information, and enrollment. These five tables are linked by a family identifier assigned at the time of entry into the tracking system and by the patient's social security number and unique state Medicaid

identification number. **An** additional table is used to provide the patient-provider link that is the basis of the capitation system.

Application Tracking

File folders are assembled with the last name of the parent, the postmark date of the application, an application tracking record, and all application documentation for each application received. Families are sent a letter requesting additional or missing information if necessary. When payment has been included in the application, the check, cash, or money order is removed and deposited in the plan’s bank account.

Application information is entered into the data system and a unique family ID is generated at the time of entry for the purpose of linking related records within the system. The application tracking record for each application is maintained and updated throughout the processing of the application.

Application Processing.

Processing procedures differ slightly for each of the four different types of applications. The full application allows CHP+ eligibility technicians to use all income and resource information to assign families a “rating” or a letter assignment of financial condition. The processing of each of the three short “easy enrollment” applications follows slightly different verification procedures depending upon which other state program qualifies the family for “easy enrollment” in the CHP+.

***Processing the Full Application***

Upon receipt of a full application, the postmark is cut from the envelope and attached to the application before it is placed in a file folder labeled with a tracking sheet. There is a checkpoint on the tracking sheet for each piece of information which technicians must include before they can proceed with eligibility determination. Each checkpoint also represents a piece of data which is captured in the plan’s information system.

Once the application is complete and plan eligibility technicians have received all necessary information, the next step is the entry of the family’s application data into the information system.

Method I

The data entry form is modeled after the CCHP full application. This form stores work income, pay-period type, non-work income, previous year’s income, expenses, assets, income exceptions, and other miscellaneous fields required for eligibility determination. All family size, income and/or expense, resource, and spend down criteria listed in Section **4.1** are used to determine the family’s eligibility using the

CCHP rules-based information system. The current year's total income is calculated as the sum of the work and the total non-work income fields.

The family income used for determining eligibility and family cost sharing is the sum of the gross income, adjusted home equity, adjusted business equity, and adjusted personal assets less the family deduction, any other liabilities, and the sum of all extraordinary (spend down) expenses. The applicant is then screened for Medicaid as described in Section **4.4.1**.

Method II

When eligibility is determined using the monthly expenses method, annualized monthly expenses are used to determine the family's gross income. The family's cost sharing responsibilities and the child's eligibility for Medicaid is determined using the algorithm described under Method I above.

Method III

Where expenses are not available and/or the family has indicated an "Income Exception," partial income information is then compared to the income reported on the most recently filed income tax return. If an income exception is noted, the smaller of the two years' incomes is used. Otherwise the larger of the two years' incomes is used. Again, the family's cost sharing responsibilities and the child's eligibility for Medicaid is determined using the algorithm described under Method I above.

***Processing the Short Form Applications and Creating the Patient Record***

Upon receipt of a short form application, the postmark is cut from the envelope and attached to a copy of the application before it is placed in a file folder labeled with a tracking sheet.

In the case of each of the short form applications, verification of income is received from the plan's sister agencies. This income verification allows the plan to determine the amount of cost sharing (premiums and copayments) for which the family is responsible. Once the child is screened for Medicaid eligibility, all children registered through the short form application are determined eligible.

Decentralized Eligibility and the WEB Site

The Colorado Child Health Plan has successfully piloted one fully operational decentralized eligibility site, The Resource Center in Grand Junction on the Western Slope. This site uses a duplicate of the CCHP database and performs the same functions locally as those which occur at the plan's Denver offices. Data is sent from The Resource Center to the CCHP central database at least weekly via the Internet and is matched and integrated into the plan's central database.

To replicate this decentralized eligibility site system, the plan has opted to develop a Web site data submission form. This can be viewed at [www.uchsc.cchp.edu](http://www.uchsc.cchp.edu). The plan has received requests to perform decentralized Web site eligibility from six organizations located throughout the state. The next site to become operational will be the Denver Health and Hospitals system of eight neighborhood clinics, several school-based health centers and the city's major trauma hospital located in Denver County. Training for Web site submission was completed October 1, 1997.

Other decentralized eligibility sites include a community health center network in south central rural Colorado, a provider's office in Pueblo, a health department in Fort Collins and another Resource Center located just west of Colorado Springs.

#### Enrollment in Health Plans

Parents who live in areas served by HMOs must select an HMO for their children to enroll in the CHP+. A family can select an HMO by: 1) indicating their HMO choice on the application form when they apply to the CHP+; ~~or~~ 2) selecting an HMO when they apply for the CHP+ at the time of service at a provider site. Families who live in an area without access to an HMO will receive care through the CHP+ provider network (expanded from the current CCHP outpatient network to provide comprehensive benefits).

CHP+ applications will include information on health plan service area and, when it is available, quality indicators. Parents will be instructed to select an HMO for their child(ren) and offered a 1-800 number to answer questions they may have. A parent who seeks care for their child at a provider's office and applies for the CHP+ at the time of the visit can receive outpatient services through the CHP+ provider network on a fee-for-service basis until their HMO enrollment is effective. The child can receive outpatient fee-for-service care through the CHP+ for a period of 14 to 45 days until the effective date of HMO coverage. If the family selects ~~an~~ HMO at the time of treatment, they will have **30** days after the initial selection to change health plans. (Future health plan changes can be made under rare circumstances for good cause.

#### Redetermination of Eligibility

Children enrolled in the CHP+ will be guaranteed eligibility for twelve months. A renewal packet will be mailed to families 45 days before the day their CHP+ coverage will end without renewal. A reminder card to re-apply to the CHP+ will be mailed **30** days before the end-of-coverage date. Families will be given a 30-day grace period of continued coverage in month 13 with a financial penalty for failing to renew on time.

#### **4.4. Describe the procedures that assure:**

**4.4.1. Through intake and follow-up screening, that only targeted low-income children who are ineligible for either Medicaid or other creditable coverage are furnished child health assistance under the state child health plan. (Section 2102)(b)(3)(A))**

**Medicaid Screening**

Legislation for the original Colorado Child Health Plan denies coverage to any child who is eligible for Medicaid. The method described below is now used by the CCHP and will be used by the CHP+.

Because Colorado’s Medicaid eligibility depends on age and income, each child in a family must be separately screened for possible Medicaid eligibility. The plan’s rules-based rating system applies the Medicaid rules by the child’s age and the family’s calculated income. Then, if one child of several in a family is found to be eligible for Medicaid, the plan’s information system will allow technicians to enroll only those children not eligible for Medicaid in the plan’s patient registration system.

Screening for Medicaid eligibility occurs at the time of enrollment. For each child listed on the application, the system displays whether or not she is eligible for Medicaid based on the algorithm described below. The operator may elect to enroll the child if the child is determined in fact not to be eligible based on some criteria not recognized by the system such as provision of a Medicaid denial.

For the purposes of the system, Medicaid eligibility is determined from a combination of the gross income determined above, the family size, the family’s personal assets, and the equity in the family’s vehicles. If the total personal assets less deductions is greater than \$1,000 or if the sum of the vehicle equity and the personal assets less deductions is greater than \$2,500, the family is deemed not eligible for Medicaid. Otherwise, if the age of the child is less than 6 and the family’s total income is less than 133% of the federal poverty level, or if the child is less than 14 (born after September 30, 1983), and the family’s total income is less than 100% of the federal poverty level, then the user is advised that the child may be eligible for Medicaid and must deliberately override the determination in order to enroll the child.

Until July 2000, the family of a child found to be eligible for Medicaid will receive a letter indicating that the child cannot be insured by the plan because he/she appears to be eligible for Medicaid. The family will be instructed to make application for Medicaid at the appropriate county social services office and will be given a 1-800 phone number to call with further questions. The family will be notified that the application will be reconsidered if parents have applied for and been denied Medicaid within the last six months if they send a copy of the Medicaid denial to the CHP+.

CHP+ will pursue cooperative agreements with interested county social service offices to exchange information collected for CHP+ and Medicaid applications. Families who apply for Medicaid will be informed about the CHP+, and families applying for CHP+ will be informed about Medicaid. Medicaid applicants with

children who do not qualify for that program will be asked to sign a release form permitting the information provided for their Medicaid application to be used to determine the children’s eligibility for the CHP+. Likewise, CHP+ applicants found to be Medicaid eligible will be asked to sign a release permitting the information provided for the CHP+ application to be used to determine the child’s eligibility for Medicaid.

**Other Creditable Coverage Screening**

The CHP+ application, like the current Colorado Child Health Plan’s application, will ask the applicant to report any health insurance coverage. If the family reports creditable coverage (most group health plans and health insurance coverage), the child will be found ineligible. Providers contracting with the CHP+ will be required contractually to notify the plan whenever they have reason to believe a member has coverage other than the CHP+. The CHP+ will then verify coverage with the insurance carrier and notify the family that they will be disenrolled if the family continues to carry other coverage.

**4.4.2. That children found through the screening to be eligible for medical assistance under the state Medicaid plan under Title XIX are enrolled for such assistance under such plan. (Section 2102)(b)(3)(B))**

The Child Health Plan Plus will undertake a two-phase approach to ensure that Medicaid-eligible children are enrolled in Medicaid. The first phase will be a screening of CHP+ applicants for Medicaid eligibility. Medicaid-eligible children will be referred to county social service offices and application information will be shared between Medicaid and CHP+ if the county social service agency and family agrees to do so. CHP+ eligibility staff will follow up on these referrals with clients and will notify county eligibility staff that they have made a referral. Children who appear to be Medicaid eligible will only be enrolled in the CHP+ after they have received a denial letter from a county office.

The second phase of coordinated Medicaid and Child Health Plan Plus eligibility determination will be based on the development of the Colorado Benefits Management System, an integrated eligibility system. Providers, families, and public agencies will be able to determine eligibility for a range of public medical assistance by July 2000 with the establishment of the Colorado Benefits Management System (CBMS). The CBMS will allow families who apply for the CHP+ but are determined to be Medicaid eligible to automatically enroll in Medicaid without requiring the family to go to the appropriate county social services office. The CHP+ will pilot this rules-based eligibility system that will later be incorporated into the CBMS upon its implementation.

**4.4.3. That the insurance provided under the state child health plan does not substitute for coverage under group health plans. (Section 2102)(b)(3)(C))**

The CHP+ application will ask whether the applicant has been covered under an employer health benefits plan with at least a 50% employer contribution during the three months prior to application. A person will be ineligible for the CHP+ if they have had such coverage in the noted time period. The CHP+ application will ask whether the applicant currently has group or individual coverage and will deem the child ineligible if he/she has such coverage. The CHP+ eligibility technicians will verify this information with the families' employers if necessary.

**4.4.4. The provision of child health assistance to targeted low-income children in the state who are Indians (as defined in section 4(c) of the Indian Health Care Improvement Act, 25 U.S.C. 1603(c). (Section 2102)(b)(3)(D))**

The current Colorado Child Health Plan has contracts with Indian Health Services in all areas of the state to allow tribal clinics to deliver health care to Native Americans. The CHP+ will amend and continue these contracts. Because the federal legislation governing the Indian Health Services has regulations against the use of managed care, the CHP+ will pay these facilities fee-for-service. These primary care contracts, will continue to allow Native Americans full access to specialty providers through a managed care environment (though still paid fee-for-service.) This access to specialty care was previously unavailable.

CHP+ will work directly with the Indian Health Resource Center to reach out to Native Americans living in the Denver metro area, home to nearly half of Colorado's Native Americans. CHP+ will conduct outreach to Native Americans living in the remainder of the state, much of which is rural, through local public health nurses and case workers. In Southwestern Colorado, case workers at the San Juan Basin Health Department in Durango will provide outreach at two Indian Health Centers at the Ute Mountain Ute Indian Reservation near Towaoc and Southern Ute Indian Reservation in Ignacio.

**4.4.5. Coordination with other public and private programs providing creditable coverage for low-income children. (Section 2102)(b)(3)(E))**

Through coordination with sites that are capable of determining eligibility for a variety of other public and private programs (FQHCs, DSH hospitals, local health departments, and family planning clinics) the state will ensure that eligible individuals are enrolled in the appropriate program through a one-stop shopping approach. Please see Section 2.2 for a discussion of the Child Health Plan Plus' coordination with other public and private programs providing creditable coverage for low-income children. The CHP+ will continue the Colorado Child Health Plan's

coordination of benefits procedures for public health services. The CHP+ will act as a “wrap-around” to other state programs providing direct services (not insurance) – especially the Health Care Program for Children with Special Needs (HCP) and clinical activities of the state’s health departments and nursing services. This will entail coordination of benefits and CHP+ provider communications with the HCP program.

Easy enrollment procedures and collaborative outreach efforts, described in detail in Section 5.1 further the plan’s goal to coordinate with other public and private programs.

**Section 5. Outreach and Coordination (Section 2102(c))**

**Describe the procedures used by the state to accomplish:**

**5.1. Outreach to families of children likely to be eligible for assistance or under other public or private health coverage to inform them of the availability of, and to assist them in enrolling their children in such a program: (Section 2102(c)(1))**

Outreach will be conducted using methods proven successful by the Colorado Child Health Plan and Medicaid, and through state programs, county agencies, and providers. At the state level, the Colorado Departments of Health Care Policy and Financing; Human Services; Public Health and Environment; and Labor and Employment are working together to make available one-stop access to public assistance for low-income families where possible. CHP+ will work at state and county levels to encourage “one-stop” access to CHP+ information and enrollment. CHP+ outreach will be conducted through established cooperative arrangements with agencies, programs and providers, using methods described below.

Two types of outreach will be conducted.

First, children enrolled in the current (outpatient benefits-only ) Colorado Child Health Plan (CCHP) will automatically be eligible for the new, full coverage Child Health Plan Plus. Through direct mail, these families will receive information to enroll in the new program. HMOs will be encouraged to include CCHP network primary care providers (PCPs), including essential community provides (ECPs) in their networks to assure continuity of care and continuous coverage.

The second type of outreach will be to families with children likely to be eligible for the Child Health Plan Plus, but who are not currently enrolled in the Colorado Child Health Plan. This outreach will occur at locations and through agencies where families access public assistance and/or health care services.

Outreach and application assistance will target eligible families through:

- Medicaid outstation and eligibility sites and presumptive eligibility sites at FQHCs, DSH hospitals, community health centers, and family planning clinics;
- Family resources centers;
- Locations of contracted providers (private physicians’ offices, hospitals, and others)
- Medicaid and TANF eligibility determination sites at county social service agencies;
- Job training centers and employment offices;
- Eligibility verification agreements with other state programs including: Public Schools’ Free and Reduced-Price Meals Program (FRM); the Health Care

Program for Children with Special Needs (HCP); the Special Nutritional Program for Women, Infants, and Children (WIC); Commodity Supplemental Foods Program (CSFP); and the Colorado Indigent Care Program (CICP). Children eligible for these programs, after screening for Medicaid, can automatically enroll in the CHP+.

- County public health departments and nursing services.
- Colorado Child Health Plan Satellite Eligibility Determination sites (SEDs). SED sites are established at agencies and providers submitting qualifying proposals. CHP+ will continue CCHP's solicitation of proposals from safety net providers, public health services, county social service departments, school districts, hospital districts, family resource centers, and others. CHP+ will reimburse these sites to provide application assistance and/or eligibility determination. SED sites may do so on paper via mail or Fax, or electronically via the CHP+ Web site.
- Public schools through distribution of materials to families in school mailings, newsletters, and at back-to-school nights.

Outreach and application assistance will target:

- Families of migrant workers at community/migrant health centers. The CHP+ will work with the Colorado Migrant Health Program to develop specific outreach activities for migrants statewide.
- Homeless children at homeless health centers and other service agencies for the homeless.
- Children in rural and frontier areas. CHP+ will work, as CCHP has, with public health nurses, school enrollment campaigns, community/migrant health centers and private physicians and hospitals that are located throughout the state. The Colorado Child Health Plan currently has contracted providers in all 63 counties.

Through the CHP+'s Website on the Internet, agencies and individuals can access all information about the Child Health Plan Plus, complete an application on line, and down-load completed applications and patient enrollment records to the CHP+ administrative offices.

#### Outreach and Coordination Methods

The Child Health Plan Plus will be marketed statewide as a full benefit health plan, following seven primary strategies: 1) direct appeal to eligible families through press releases, public service announcements, and video; 2) outreach through school districts 3) outreach through employers; 4) outreach through collaboration with local county agencies; 5) outreach through regional health and social service agencies; 6) outreach through other state programs; and 7) outreach through collaboration with the Colorado Foundation for Families and Children. All CHP+ materials will be designed for easy reading and will be printed in English and Spanish.

Assumptions about the target population for CHP+ are based on the experience of the Colorado Child Health Plan. For an audience consisting of families with a variety of financial needs, the plan must appeal to both the chronically needy who have regular interaction with human service agencies, and to the working poor who have traditionally avoided government programs. Outreach efforts for the Child Health Plan Plus, therefore, will use the Colorado Child Health Plan's technique of portraying itself as a low-cost health plan supported by state government rather than as a government program.

The Child Health Plan Plus will be marketed in phases by geographic region in **1998** following the four outreach strategies described above. As the Child Health Plan Plus contracts with HMOs, Colorado Child Health Plan families living in a region covered by those HMOs will be offered the option of upgrading their children's coverage to comprehensive coverage. These full benefits will be available to families either through a participating HMO or directly through the CCHP network of providers if they live in an area without HMO coverage.

Beginning in November **1997**, parents of CCHP members in areas of the state with HMOs will receive letters offering the opportunity to upgrade their children's coverage. The packet will contain a letter, a chart, a booklet, and a response form. The letter will describe two options: (1) continue with CCHP outpatient coverage with no change; or (2) change to a CHP+ HMO full-service plan and pay a monthly premium if their family income is greater than **62% FPL**. A chart will describe coverage options, the plans they can choose, the sliding scale of monthly premiums, based on income and family size. (See Attachment **6** for family cost sharing requirements.) A booklet designed specifically for a lower-income audience will describe how managed care plans work, and how to make a good choice for one's children. New applicants on or after January 1, **1998** will not have the option to enroll in the CCHP outpatient package. These applicants will only be able to enroll in the CHP+ comprehensive package.

Parents of CCHP members in areas of the state that do not have HMO penetration will receive a letter describing two options: (1) continue with CCHP outpatient coverage with no change; or (2) upgrade their CCHP coverage with inpatient and mental health services through the CCHP provider network for an additional monthly premium.

CHP+ customer service personnel will staff the Toll-Free telephone line. A recorded telephone message will include options for callers to hear about the expanded coverage and about choosing a managed care plan.

The main outreach methods are:

Direct Appeal to Eligible Families through Press Releases, Public Service Announcements, and Video

Radio and television public service announcements will be aired to support mailings of materials to community human service agencies. A toll free number to call for more information will be featured in the public service announcements, printed materials, and press releases. Frequent news releases will be sent to the press about the increased coverage available. Radio stations, TV and cable stations, all Colorado daily and weekly newspapers, and specialty publications and newsletters for professional associations in the areas of children's health care, parenting, day care, and education will receive the press releases.

Outreach methods other than written materials will be employed whenever possible. A video loop current under development will explain the health plan and will be shown in waiting rooms of providers' offices and eligibility determination sites. All outreach materials will prominently feature the **1-800** telephone number. Callers to the toll-free number will hear a recorded message about the plan, speak to a customer service representative, or leave their name and address to receive an application. Spanish-speaking callers will speak with a Spanish-speaking operator at the CDPHE Family Health Line or will be transferred to bilingual CHP+ staff.

Outreach through School Districts

The CHP+ will collaborate with the Department of Education to conduct Back-to-School Enrollment Campaigns in school districts statewide, and to develop School-Based Enrollment Projects in selected communities. School districts will verify CHP+ eligibility when applicants are qualified for the meal program. Children who qualify for Reduced-Price Meals will be automatically eligible for CHP+, and those who qualify for the free meals will be screened for Medicaid eligibility during the eligibility determination process. Back-to-school enrollment campaigns also reach out to eligible families who have not applied for the school meal program. Applications and enrollment forms will be available to all eligible families through school employees who are most likely to speak with eligible families: the health aid, assistant principal, principal, school secretary, PTA contact, social worker, English as a Second Language coordinator, Child Find coordinator, physical education instructor, coach, and that teacher who has particularly close rapport with students and parents. Enrollment kits with flyers, enrollment pamphlets and applications will be mailed to schools identified by the district as interested in helping to conduct CHP+ outreach. Fliers will also be sent home to each family with the school's newsletter.

Outreach through Employers

To encourage employers to provide information to employees with uninsured children, the Child Health Plan Plus will include employers in regional planning

meetings, make presentations to chambers of commerce and business organizations, send press releases to trade publications, and contact employers through direct mail.

#### Outreach through Collaboration with Local County Agencies

In order to involve concerned citizens at the community level, the CHP+ will invite county health departments to host annual regional planning meetings for health care providers, human service agencies, school districts, and community leaders to discuss the health care needs of underserved children in their community and to learn how CHP+ can help.

Outreach and training sessions on CHP+ eligibility will be conducted for the staff of county public health departments, county social services, WIC coordinators, Medicaid case workers, family resource centers, school nurses, providers, the Health Care Program for Children with Special Needs, Community-Centered Boards, Early Childhood Connections, and Child Find.

#### Outreach through Regional Health and Social Service Agencies

The Child Health Plan Plus will continue the Colorado Child Health Plan's relationships with providers, social services agencies, and public health nurses to conduct outreach and application assistance. CHP+ eligibility will be determined at community-based health care providers including Federally Qualified Health Centers (FQHCs), Disproportionate Share Hospitals (DSHs), community health centers, family planning clinics, rural health centers, school based health centers, and Residency Program family medicine centers. Outreach materials will be distributed at physician's offices where staff will assist families with CHP+ applications.

#### Outreach through Other State Programs

Through collaboration with the administration of six other state programs CHP+ will offer **an** enrollment shortcut to children of families in which at least one family member is enrolled in the school Free and Reduced-Price Meal Program (FRM); Special Nutrition Program for Women, Infants, and Children (WIC); Commodity Supplemental Foods Program (CSFP); the Health Care Program for Children with Special Needs (HCP); and the Colorado Indigent Care Program (CICP). With the cooperation **of** the county level staff for these five programs, all children in such a family who are age 17 and under and ineligible for Medicaid can enroll in CHP+ on one short enrollment form.

Outreach for the CHP+ and Medicaid will continue to be conducted through the Governor-sponsored Bright Beginnings Program, a home visitation program for newborns. Home visitors give new parents CCHP and Medicaid program brochures and answer questions of new parents. Visitors call parents at times coinciding with the child's immunization schedule to remind parents to have their children immunized and to inform them of the availability of free or reduced price immunizations and health care coverage.

### Outreach through Collaboration with the Colorado Foundation for Families and Children

The Foundation for Families and Children, a private partner to state government to promote and sustain the health, education, and well being of children and families in Colorado communities, will reach out to eligible families through several foundation-sponsored coalitions:

- The Colorado Connection for Healthy Kids is a collaboration of four state agencies and ten state organizations dedicated to promoting comprehensive school health.
- The Rural County Project is a local development project designed to support to 29 rural counties.
- The Denver Early Childhood Connections is a parent-governed community development and family support agency for children **0-3** years of age receiving Part H services.
  - The transitions from School to Work Program helps families find day care, transportation, health care, and job training.
  - The Family Preservation and Family Support Program provides training for family advocates, home visitation nurses, and counseling specialists.
  - The Colorado Family Resource Network is an association of 150 family support agencies and community-based organizations, supported by grants from the Colorado Department of Human Services.

## **5.2 Coordination of the administration of this program with other public and private health insurance programs: (Section 2102(c)(2))**

The CHP+ outreach efforts described above will be coordinated as often **as** possible with Medicaid and other children's health coverage or direct services.

Children can enroll or receive assistance in enrolling in Medicaid or CHP+ at Medicaid outstationed eligibility sites and presumptive eligibility sites located at FQHCs, family planning clinics, and DSH hospitals. County social service departments will inform families who have been denied Medicaid eligibility of the CHP+ and will share information collected in the eligibility determination process with CHP+ if the county and family agrees to do **so**. CHP+ will refer applicants who appear to be Medicaid eligible to county social service offices and will conduct follow up of these children. CHP+ will conduct eligibility training for county social services and give these offices CHP+ brochures and applications for children who are not eligible for Medicaid but may be eligible for the CHP+.

CHP+ outreach and application assistance will be available at state agencies where families apply for job training and placement, food assistance, and services for children with special needs. Application assistance, eligibility determination, and application submission will also be available through CHP+ Satellite Eligibility Sites (SEDs). CHP+ SEDs will include community-based health providers such as school-based health

centers and FQHCs, public health service providers, WIC providers, Health Care Program for Children with Special Needs offices, county departments of social services, school districts, and family resource centers.

Please see Sections 2.2.1 ,2.2.2, 4.4.2 and 5.1 for a description **of** how children who are determined to be eligible for Medicaid or other children’s health insurance or services will be referred to and enrolled in those programs.

Section 6. Coverage Requirements for Children's Health Insurance (Section 2103)

☐

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 7.

6.1. The state elects to provide the following forms of coverage to children:  
(Check all that apply.)

6.1.1. ☐

Benchmark coverage; (Section 2103(a)(1))

6.1.1.1. ☐

FEHBP-equivalent coverage; (Section 2103(b)(1))  
(If checked, attach copy of the plan.)

6.1.1.2. ☐

State employee coverage; (Section 2103(b)(2)) (If checked, identify the plan and attach a copy of the benefits description.)

6.1.1.3. ☐

HMO with largest insured commercial enrollment (Section 2103(b)(3)) (If checked, identify the plan and attach a copy of the benefits description.)

6.1.2. ☒

Benchmark-equivalent coverage; (Section 2103(a)(2)) Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. See attached actuarial report that meets the requirements specified in Section 2103(c)(4).

6.1.3. ☐

Existing Comprehensive State-Based Coverage; (Section 2103(a)(3)) [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If "existing comprehensive state-based coverage" is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for "existing comprehensive state-based coverage."

6.1.4. ☐

Secretary-Approved Coverage. (Section 2103(a)(4))

- 6.2. The state elects to provide the following forms of coverage to children:  
(Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) (Section 2110(a))

**BENEFITS IN COUNTIES WHERE HMOS ARE AVAILABLE**

- 6.2.1. ☒ Inpatient services (Section 2110(a)(1))  
Inpatient services includes all physician, surgical and other services delivered during a hospital stay. Inpatient services covered in full with no copayments.
- 6.2.2. ☒ Outpatient services (Section 2110(a)(2))  
Outpatient services include outpatient surgery -- covered in full with no copayments. Clinic services and other ambulatory health care services have a \$2 co-pay for below 150% FPL and \$5 copayment for above 150% FPL.
- 6.2.3. ☒ Physician services (Section 2110(a)(3))  
Physician services include medical office visits with a physician, mid-level practitioner or specialist. Covered in full with \$2 copayment for below 150% FPL and \$5 copayment above 150% FPL. Preventive care and immunizations covered in full with no copayment.
- 6.2.4. ☒ Surgical services (Section 2110(a)(4))  
Covered in full. See 6.2.1 for outpatient surgical services and 6.2.2 for inpatient surgical services.
- 6.2.5. ☒ Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))  
See section 6.2.2.
- 6.2.6. ☒ Prescription drugs (Section 2110(a)(6))  
Covered for outpatient prescription drugs with \$1 co-payment below 150% FPL and \$3 generic prescription copayment for above 150% FPL and \$5 copayment for brand name prescription above 150% FPL.
- 6.2.7. ☐ Over-the-counter medications (Section 2110(a)(7))

- 6.2.8. ☒ Laboratory and radiological services (Section 2110(a)(8))  
Covered in full with no co-payment for physician-ordered services.
- 6.2.9. ☒ Prenatal care and pre-pregnancy family services and supplies (Section 2110(a)(9))  
Prenatal maternity care covered in full with no copayment.
- 6.2.10. ☒ Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))  
45 days of inpatient mental health services covered with an exception clause to review cases for children needing longer hospital stays. No copayments.
- 6.2.11. ☐ Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11))  
Outpatient mental health services covered with a 20 visit limit.  
\$2 copayment for below 150% FPL and \$5 for above 150% FPL.
- 6.2.12. ☒ Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))  
\$2,000 maximum per year paid by plan. Coverage for lesser of purchase price or rental price for medically necessary durable medical equipment, including home administered oxygen. No copayments.
- 6.2.13.0 Disposable medical supplies (Section 2110(a)(13))
- 6.2.14. ☒ Home and community-based health care services (See instructions) (Section 2110(a)(14))  
Home health care covered in full with no copayments.
- 6.2.15.0 Nursing care services (See instructions) (Section 2110(a)(15))

- 6.2.16. ☒ Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16))
- 6.2.17. ☒ Dental services (Section 2110(a)(17))  
Coverage for preventive dental services and emergency assessments with \$2 copayment for below 150% FPL and \$5 copayment for above 150% FPL.
- 6.2.18. ☐ Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))
- 6.2.19. ☐ Outpatient substance abuse treatment services (Section 2110(a)(19))
- 6.2.20. ☐ Case management services (Section 2110(a)(20))
- 6.2.21. ☐ Care coordination services (Section 2110(a)(21))
- 6.2.22. ☒ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))  
30 visits per diagnosis covered per year. \$2 copayment for below 150% FPL and \$5 copayment for above 150% FPL.
- 6.2.23. ☐ Hospice care (Section 2110(a)(23))  
Covered in full with no co-payment.
- 6.2.24. ☐ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (Section 2110(a)(24))
- 6.2.25. ☐ Premiums for private health care insurance coverage (Section 2110(a)(25))
- 6.2.26. ☒ Medical transportation (Section 2110(a)(26))  
Hospital and emergency room transport covered. \$15 copayment for all below 185% FPL. Copayments will be waived with admission into hospital from ER.

- 6.2.27.0

Enabling services (such as transportation, translation, and outreach services (See instructions) (Section 2110(a)(27))
- 6.2.28.☒

Any other health care services or items specified by the Secretary and not included under this section (Section 2110(a)(28))

**Neurobiologically-based mental illnesses** will be required to be treated as any other illness or condition under Colorado state law. Illnesses in this category include schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive compulsive disorder and panic disorder. There will be a \$2 copayment for below 150% FPL and a \$5 copayment for above 150% FPL for all office visits and no copayments for admissions.

**Organ transplant** coverage will include liver, heart, heart/lung, cornea, kidney, and bone marrow for aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk state II and state III breast cancer, and Wiskott Aldrich Syndrome only. Peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants. Transplants will be covered only if they are medically necessary and the facility meets clinical standards for the procedure. No copayments.

**Vision Services:** Vision screenings are covered as age appropriate preventive care. Referral is required for refraction services. There is a \$50 annual benefit for eyeglasses. Vision therapy is covered, Copayments are \$2 for below 150% FPL and \$5 for above 150% FPL.

**Audiological services:** Hospitals are mandated to cover newborn hearing screenings. Coverage will include assessment and diagnosis. Hearing aides are covered for congenital and traumatic injury with a maximum payment of \$800 per year paid by plan. No copayments.

**Intractable pain treatment** will be included as a benefit with \$2 co-payment for below 150% FPL and \$5 copayment for above 150% FPL.

**Autism coverage** will be included with \$2 co-payment for below 150% FPL and \$5 copayment for above 150% FPL.

**Skilled nursing facility** covered in full with no co-payments. Care must follow a hospital confinement and the skilled nursing facility confinement must be the result of an injury or sickness that was the cause of the hospital

confinement. Benefits will not be paid for custodial care or maintenance care or when maximum medical improvement is achieved and no further significant measurable improvement can be anticipated.

Diagnosis and referral services, as defined by Guidelines for Adolescent Preventive Services (GAPS) for **alcohol and substance abuse** is covered in full with no co-payments. Alcohol and substance abuse treatment not included.

The following is a list of services to be provided through the Child Health Plan Plus provider network and the family co-payments for these services. The benefits in the HMO package that are not included in the provider network package are: 1) dental services; **2) hospice care**; 3) medical transport; 4) autism; and **5) skilled nursing facility**. The family cost sharing for the HMO package and provider network package are slightly different, as described in this section and in Attachment 7.

## BENEFITS ~~IN~~ COUNTIES WHERE HMOS ARE NOT AVAILABLE

- 6.2.1. ☒ Inpatient services (Section 2110(a)(1))  
Inpatient services includes all physician, surgical and other services delivered during a hospital stay. Inpatient services covered in full with no copayments.
- 6.2.2. ☒ Outpatient services (Section 2110(a)(2))  
Outpatient services include outpatient surgery -- covered in full with no copayments. Clinic services and other ambulatory health care services have a \$2 co-payment for all families.
- 6.2.3. ☒ Physician services (Section 2110(a)(3))  
Physician services include medical office visits with a physician, mid-level practitioner or specialist. Covered in full with \$2 copayment for all families. Preventive care and immunizations covered in full with no copayment.
- 6.2.4. ☐ Surgical services (Section 2110(a)(4))  
Covered in full. See 6.2.1 for outpatient surgical services and 6.2.2 for inpatient surgical services.
- 6.2.5. ☒ Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))  
See section 6.2.2.
- 6.2.6. ☒ Prescription drugs (Section 2110(a)(6))  
Covered for outpatient prescription drugs with \$2 copayment for generic or name-brand drugs for all families.
- 6.2.7. ☐ Over-the-counter medications (Section 2110(a)(7))

- 6.2.8. ☒ Laboratory and radiological services (Section 2110(a)(8))  
Covered in full with no co-payment for physician-ordered services.
- 6.2.9. ☒ Prenatal care and pre-pregnancy family services and supplies (Section 2110(a)(9))  
Prenatal maternity care covered in full with no copayment.
- 6.2.10. ☐ Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))  
**45** days of inpatient mental health services covered with an exception clause to review cases for children needing longer hospital stays. No copayments.
- 6.2.11. ☒ Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11))  
Outpatient mental health services covered with a **20** visit limit.  
**\$2** copayment for all families.
- 6.2.12. ☒ Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))  
\$2,000 maximum per year paid by plan. Coverage for lesser of purchase price or rental price for medically necessary durable medical equipment, including home administered oxygen. No copayments.
- 6.2.13.0 Disposable medical supplies (Section 2110(a)(13))
- 6.2.14. ☒ Home and community-based health care services (See instructions) (Section 2110(a)(14))  
Home health care covered in full with no copayments.
- 6.2.15.0 Nursing care services (See instructions) (Section 2110(a)(15))

- 6.2.16. ☒ Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16))
- 6.2.17. ☐ Dental services (Section 2110(a)(17))
- 6.2.18. ☐ Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))
- 6.2.19. ☐ Outpatient substance abuse treatment services (Section 2110(a)(19))
- 6.2.20. ☐ Case management services (Section 2110(a)(20))
- 6.2.21. ☐ Care coordination services (Section 2110(a)(21))
- 6.2.22. ☒ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))  
30 visits per diagnosis covered per year. \$2 copayment.
- 6.2.23. ☐ Hospice care (Section 2110(a)(23))
- 6.2.24. ☐ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (Section 2110(a)(24))
- 6.2.25. ☐ Premiums for private health care insurance coverage (Section 2110(a)(25))
- 6.2.26.0 Medical transportation (Section 2110(a)(26))
- 6.2.27. ☐ Enabling services (such as transportation, translation, and outreach services (See instructions) (Section 2110(a)(27))
- 6.2.28. ☒ Any other health care services or items specified by the Secretary and not included under this section (Section 2110(a)(28))

Neurobiologically-based mental illnesses will be required to be treated as any other illness or condition under Colorado state law. Illnesses in this category include schizophrenia, schizoaffective disorder, bipolar affective

disorder, major depressive disorder, specific obsessive compulsive disorder and panic disorder. There will be a \$2 co-payment for all office visits and no co-pays for admissions.

**Vision Services:** Vision screenings are covered as age appropriate preventive care. Referral is required for refraction services. There is a \$50 annual benefit for eyeglasses. Vision therapy is covered. Copayments are \$2.

**Audiological services:** Hospitals are mandated to cover newborn hearing screenings. Coverage will include assessment and diagnosis. Hearing aides are covered for congenital and traumatic injury with a maximum payment of \$800 per year paid by plan. No copayments.

**Intractable pain treatment** will be included as a benefit with \$2 co-payment.

Diagnosis and referral services, as defined by Guidelines for Adolescent Preventive Services (GAPS) for **alcohol and substance abuse** is covered in full with no co-pays. Alcohol and substance abuse treatment not included.

6.3. Waivers - Additional Purchase Options. If the state wishes to provide services Under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate waiver. Review and approval of the waiver application(s) will be distinct from the state plan approval process. To be approved, the state must address the following: (Section 2105(c)(2) and(3))

6.3.1. ☐ Cost Effective Alternatives. Payment may be made to a state in excess of the 10% limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the state to administer the plan, if it demonstrates the following:

6.3.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; Describe the coverage provided by the alternative delivery system. The state may cross reference section 6.2.1 - 6.2.28. (Section 2105(c)(2)(B)(i))

6.3.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above; and Describe the cost of such coverage on an average per child basis. (Section 2105(c)(2)(B)(ii))

6.3.1.3. The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(d)(5)(F) or 1923 of the Social Security Act. Describe the community based delivery system. (Section 2105(c)(2)(B)(iii))

6.3.2. ☐ Purchase of Family Coverage. Describe the plan to provide family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: (Section 2105(c)(3))

6.3.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children. (Section 2105(c)(3)(A))

6.3.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. (Section 2105(c)(3)(B))

## Section 7. Quality and Appropriateness of Care

- ☐ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 8.

- 7.1.** Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan.  
(2102(a)(7)(A))

Will the state utilize any of the following tools to assure quality?  
(Check all that apply and describe the activities for any categories utilized.)

- 7.1.1. ☒ Quality standards
- 7.1.2. ☒ Performance measurement
- 7.1.3. ☒ Information strategies
- 7.1.4. ☒ Quality improvement strategies

The Child Health Plan Plus will use quality standards, performance measures, information strategies, and quality improvement studies to assure high-quality care for CHP+ enrollees. The CHP+ program will use quality assurance methods and tools such as NCQA accreditation standards, National Association of Insurance Commissioners (NAIC) standards, Quality Improvement System for Managed Care (QISMC), Healthplan Employer Data and Information Set (HEDIS), Consumer Assessment of Health Plans Survey (CAHPS) data, standard Division of Insurance reports and quality improvement study data. The CHP+ will use standards, performance measures, consumer information, and quality improvement methods for HMOs and for the CHP+ provider network.

### Quality Assurance for Care Delivered through HMOs and through the CHP+ Provider Network to CHP+ Members

As discussed in Section 3.1, the Contracting and Quality Assurance design team will determine quality standards. Standards developed by the team will be based on a review of national quality assurance models such as the NAIC model act, NCQA accreditation standards, and the new QISMC developed by HCFA. These quality standards will address issues such as quality management and improvement, provider credentialing, preventive health and medical records. The Contracting and Quality Assurance design team will evaluate which standards will be used for contracting HMOs and which will be used for the CHP+ provider network.

Different agencies will monitor quality assurance standards for contracting HMOs and the CHP+ provider network. Plan compliance with these standards are currently reviewed by several different entities including the Division of Insurance (through its

licensing regulations), the Department of Public Health and Environment (through its licensing and examinations), the National Committee for Quality Assurance (for those plans that are accredited), and the Department of Health Care Policy and Financing (through its Medicaid contracting activities). The Department of Health Care Policy and Financing will review health plans for compliance with CHP+ standards that are not reviewed by another entity. While it is yet to be determined which entities will evaluate each quality standard, the CHP+ program (alone or in collaboration with regulators or purchasers) will conduct regular, on-site review of each contracting health plan to assure that it is operating in compliance with the CHP+ contract. CHP+ staff will review the performance of the CHP+ provider network.

The contract with the health plans will require them to collect and report HEDIS, CAHPS and complaint data. While NCQA has not yet determined whether health plans will be required to report this data separately for CHP+ enrollees or aggregated with Medicaid data, health plans will be required to report the measures that reflect the quality of children's health care in their plan. If it has an adequate quantity of children with continuous enrollment the CHP+ will produce these measures for its provider network either directly or through a contractor. The following is a draft list of required measures:

### HEDIS 3.0

- Children's access to primary care providers
- Childhood immunization rate
- Adolescent immunization rate
- Well-child visits in the first 15 months of life
- Well-child visits in the third, fourth, fifth, and sixth years of life
- Adolescent well care
- Availability of language interpretation services
- Pediatric physician specialists
- Pediatric mental health services

### CAHPS categories

- Ease of identifying a provider
- Waiting time for an appointment
- Phone waiting time for medical advice
- Access to assessment, tests, treatment and specialists
- Emergency room use
- Ease of referral to specialists
- Follow-up reminders

The CHP+ HMO contract will required plans to report their grievance data to the Division of Insurance as required by state law. CHP+ staff will record and process complaints about the CHP+ provider network.

The CHP+ will use these performance measures —HEDIS, CAHPS and grievance data—to annually evaluate a health plan’s performance and to assist enrollees in choosing a plan. While these measures will be an important component of the CHP+ quality program, the data will not be available until **1999**, after a full year of plan operation. Until then, the program will rely on quality standard reviews and reported complaints to monitor quality of care.

Consumer education tools will be developed to ensure that CHP+ enrollees have adequate information to negotiate managed care enrollment. A primary tool for consumer choice will be a report card provided to every member at open enrollment. This report card, first available in **1999**, will communicate the results of each CHP+ plan on key performance measures in HEDIS, CAHPS and complaint data. The second tool, the plan member handbook, will be developed by CHP+ in conjunction with the plans to assure that benefit, provider network, and grievance procedures are communicated effectively. Other consumer education materials will be developed as part of CHP+’s quality assurance program and will be based on the results of performance measures.

**7.2. Describe the methods used, including monitoring, to assure access to covered services, including emergency services. (2102(a)(7)(B))**

Access Assurance for Care Delivered through HMOs and the CHP+ Provider Network

In addition to setting affordable cost-sharing requirements described in Section 8, access to services will be assured by evaluating and monitoring the adequacy of provider networks and by analyzing the results of complaint data, performance measures, and client satisfaction surveys. Provider network analysis will look at the number and types of pediatricians, pediatric specialists and other providers available, their locations, and their hours. For HMOs, the primary data source for this evaluation will be the plan’s access plan. The access plan is a document required by the Colorado Division of Insurance that describes elements of its provider network including numbers, types, locations, referrals, and accommodation of members with special needs, e.g. language interpretation services and physically accessible facilities. Although the CHP+ provider network will not be required to produce this access plan, staff will evaluate this network on similar criteria. CHP+ staff will also annually evaluate access-related performance measures such as access-related complaints, ease of identifying a provider (CAHPS), phone waiting time for medical advice (CAHPS), and access to primary care physicians (HEDIS).

Adequate access to emergency services is assured for all Colorado managed care enrollees by a new Division of Insurance regulation which took effect on July 1, 1997. This regulation (4-2-17) specifies that a managed care organization cannot deny an emergency claim if a “prudent lay person would have believed that an emergency medical condition or life or limb threatening emergency existed.” The regulation also restricts the use of prior authorizations for emergency care and the denial of emergency care provided by non-network providers.

Section 8. Cost Sharing and Payment (Section 2103(e))

- ☐ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 9.

8.1. Is cost-sharing imposed on any of the children covered under the plan?

- 8.1.1. ☒ YES  
8.1.2. ☐ NO, skip to question 8.5.

8.2. Describe the amount of cost-sharing and any sliding scale based on income:  
(Section 2103(e)(1)(A))

- 8.2.1. Premiums: See Attachment 6  
8.2.2. Deductibles: None  
8.2.3. Coinsurance: No coinsurance. Copayments depending on service.  
See Sections 6.2.1-6.2.28 or Section 7 for copayments by service provided.  
8.2.4. Other:

8.3. Describe how the public will be notified of this cost-sharing and any differences based on income:

Parents of current Colorado Child Health Plan who live in an area with an **HMO** option will receive a letter offering them the opportunity to upgrade their children's coverage to the Child Health Plan Plus. The letter will describe two options: (1) continue with CCHP outpatient coverage with no change through the end of their current single year of guaranteed eligibility; or (2) upgrade their CCHP coverage to the comprehensive benefits of the CHP+ delivered by HMO for a monthly premium if their family income is at or above 63% FPL.

Parents of children in areas without HMO penetration Will have the following two options: 1) continue with CCHP outpatient coverage with no change; or 2) upgrade their CCHP coverage to the comprehensive benefits of the CHP+ delivered by the CHP+ provider network for a monthly premium if their family income is above 62% FPL.

Families who make application on or after January 1, 1998 will only have the CHP+ comprehensive benefits option which will be delivered through an **HMO** or through the CHP+ provider network if they live in an area without **HMO** coverage.

For children currently enrolled in the CCHP who enroll in the CHP+ (HMO or the provider network) above 150% FPL, the benefit expansion will entail a higher premium. For some CCHP families who enroll in the CHP+( HMO or the provider network) below 150% FPL, the enriched benefit package will cost less than the CCHP outpatient package.

A chart will describe coverage options, the cost sharing requirements for enrollment (premiums) and specific services (copayments) based on income and family size, and the plans they can choose. A booklet designed specifically for a lower-income audience will describe how managed care plans work, and how to make a good choice for one's children. CCHP customer service will be expanded to staff additional extensions for the CHP+ toll-free telephone line in English and Spanish. The recorded message will include two additional options for callers to hear about the expanded CHP+ coverage offer, and about choosing a managed care plan.

8.4. The state assures that it has made the following findings with respect to the cost sharing and payment aspects of its plan: (Section 2103(e))

- 8.4.1. ☒ Cost-sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B))
- 8.4.2. ☒ No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2))
- 8.4.3. ☒ No child in a family with income less than 150% of the Federal Poverty Level will incur cost-sharing that is not permitted under 1916(b)(1).
- 8.4.4. ☒ No Federal funds will be used toward state matching requirements. (Section 2105(c)(4))
- 8.4.5. ☒ No premiums or cost-sharing will be used toward state matching requirements. (Section 2105(c)(5))
- 8.4.6. ☒ No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. (Section 2105(c)(6)(A))
- 8.4.7. ☒ Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1,1997. (Section 2105(d)(1))

- 8.4.8. ☒ No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105)(c)(7)(B))
- 8.4.9. ☒ No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above), (Section 2105)(c)(7)(A))

**8.5. Describe how the state will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's annual income for the year involved: (Section 2103(e)(3)(B))**

Premiums for families up to 62% FPL will be waived. Monthly premiums for families between 63% and 81% of FPL will be \$2.50 per family from January 1, 1998 to June 30, 1998, and will be \$5 per family beginning July 1, 1998. Families between 82% and 100% FPL will pay a \$5 monthly family premium from January 1, 1998 to June 30, 1998, and a \$10 monthly premium per family beginning July 1, 1998. Families between 101% and 149% FPL will pay a \$7.50 monthly family premium from January 1, 1998 to June 30, 1998, and a \$15 monthly family premium beginning July 1, 1998. Families between 150% and 185% of FPL will pay a monthly premium of \$10 for one child with \$2.50 added per additional child from January 1, 1998 to June 30, 1998, and will pay a monthly premium of \$20 for one child with \$5 added per additional child beginning July 1, 1998. Please see Attachment 6 for the family premium contribution charts and Attachment 7 for the family co-payment chart.

The State has set family premium cost sharing for families with incomes at or above 150% FPL using the following steps:

1. Determine annual income at 150% FPL and 185% FPL for varying family sizes.
2. Set family monthly premium cost sharing at 1.5% of a family's income at 150% FPL.
3. Estimate the average family co-payment expenditure as \$50 per child per year and add this to the value of the family monthly premium
4. Add the \$50 average family cost-sharing to the family premium cost-sharing to verify the likelihood that the monthly combined premium and co-payment do not exceed **5%** of family income.

The prices listed in the aforementioned steps will take effect July 1, 1998. Families will have a "half-price enrollment sale" from January 1, 1998 to June 30, 1998 so that current CCHP families who pay a \$25 yearly enrollment fee will incur a more gradual increase in their cost-sharing responsibilities and CHP+ staff will have time to explain the validity of an increased family cost for an increased benefit.

The following sample family illustrates that the vast majority of families who pay the premiums and co-payments at the higher level beginning July 1, 1998 will contribute well below 5% of their family's annual income on their children's health care expenditures. A single parent family with two children at 150% FPL earns \$19,995 in annual income. Five percent of \$19,995 is \$999.75. The family's \$25 monthly premium would come to **\$300** per year. Taking this **\$300** premium expense from the five percent of the family's income (\$999.75) leaves the family with \$699.75 to spend up to five percent of their family's income on their children's health care. Paying the \$699.75 in co-payments at \$5 per doctor's visit or brand-name and prescription drug, the family could make 140 visits per year or 70 visits per child per year without their children's health care costs exceeding 5% of their family income.

In the circumstance that a child should spend greater than 5% of his/her family's annual income due to his/her high use of medical services, the child's family will be reimbursed for such expenditures. Nevertheless, in setting the premium subsidy and co-payment rates, the State expects such circumstances to be highly unlikely. It remains the responsibility of the family to detail their expenditures and request reimbursement if costs exceed the 5% limit. Please see the actuarial report for further detail.

- 8.6. The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan:
- 8.6.1. ☒

The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services (Section 2102(b)(1)(B)(ii)); OR
- 8.6.2. ☐

The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.3.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA (Section 2109(a)(1),(2)). Please describe:

**Section 9. Strategic Objectives and Performance Goals for the Plan Administration**  
(Section 2107)

**9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children:**  
(Section 2107(a)(2))

Strategic objectives are to:

1. Improve health status of children in Colorado with a focus on preventive, and early primary treatment.
2. Decrease the proportion of children in Colorado who are uninsured and reduce the financial barriers to affordable health care coverage.
3. Do not “crowd out” employer coverage.
4. Coordinate and consolidate with other health care programs providing services to children to create a seamless health care delivery system for low-income children.
5. Acquire contracts to provide statewide HMO coverage.

**9.2. Specify one or more performance goals for each strategic objective identified:**  
(Section 2107(a)(3))

1. Improve health status of children in Colorado with a focus on preventive, and early primary treatment.:  
Performance Goals:
  - Ninety percent (90%) of children under two receive the basic immunization series
  - Ninety percent (90%) of 13 year olds receive required immunizations
  - Seventy-five percent (75%) of children under 15 months receive recommended number of well child visits
  - Seventy-five percent (75%) of three, four, five, and six-year-olds receive at least one well-child visit during the year.
  - Seventy-five percent (75%) of children 12 through 17 receive at least one well-care visit during the year.
2. Decrease the proportion of children in Colorado who are uninsured and reduce the financial barriers to affordable health care coverage.  
Performance Goals:
  - Decrease in the proportion of children ≤185% of federal poverty who are uninsured by 50%.
  - Increase the percentage of uninsured children enrolled into the Child Health Plan Plus as compared to current market penetration for the Colorado Child Health Plan.

3. Do not “crowd out” employer coverage.  
Performance Goals:
  - Maintain the proportion of children  $\leq 185\%$  of federal poverty who are covered under an employer-based plan taking into account decreases due to increasing health care costs or a downturn in the economy.
4. Coordinate and consolidate with other health care programs providing services to children to create a seamless health care delivery system for low-income children.  
Performance Goals:
  - Enroll **66%** of children currently receiving benefits through the outpatient Colorado Child Health Plan into the comprehensive Child Health Plan Plus by July 1, 1998.
  - Enroll 50% of children who previously received services through the Colorado Indigent Care Program into the Child Health Plan Plus by July 1, 1999.
  - Maintain that 50% of referrals from CHP+ to Medicaid enroll in Medicaid.
5. Acquire contracts to provide statewide HMO coverage.  
Performance Goals:
  - Secure HMO coverage by one or more HMOs in each of the **63** Colorado counties.

**9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state’s performance, taking into account suggested performance indicators as specified below or other indicators the state develops:**

(Section 2107(a)(4)(A),(B))

**Objective 1: Improve health status of children in Colorado with a focus on preventive, and early primary treatment.**

Plans will be required to submit independently audited **HEDIS** data. If possible based on the number of continuously enrolled children, HCPF will produce these measures for the CHP+ provider network, either directly or through contract. HCPF will use these data to measure the success of the plans in reaching the performance goals regarding immunization and well-child care.

**Objective 2: Decrease the proportion of children in Colorado who are uninsured and reduce the financial barriers to affordable health care.**

Performance goals under this objective will be measured based on the decrease in the proportion of children in families with incomes  $\leq 185\%$  of the federal poverty level

who are uninsured compared to the proportion that were uninsured prior to the effective date of this state plan. Baseline numbers of uninsured children will be calculated from a three year average of the 1995,1996, and 1997 March supplement to the Current Population Survey produced by the Bureau of the Census. New estimates of uninsured children will be calculated as more current data become available and will be used to compare trends from year to year. CHP+ enrollment numbers will be compared to previous years and to the first year of implementation of the state plan. Clients who disenroll before their 12 months of eligibility have expired will be asked for a reason. Responses to that query will be tracked and used to evaluate the extent that the CHP+ has reduced financial barriers to affordable health care coverage.

**Objective 3: Do not “crowd out” employer coverage**

Performance goals under this objective will be measured based on the proportion of children  $\leq 185\%$  of federal poverty who are covered under an employer-based plan taking into account decreases due to increasing health care costs or a downturn in the economy. The proportion of children covered under an employer-based plan will be evaluated, and analysis will be conducted to test for evidence of “crowding out.” The baseline for comparison will be obtained from a 3-year average of the 1995,1996, 1997 March supplement to the Current Population Survey.

In addition, the eligibility determination process will include several questions relating to past employer-based insurance coverage. This will allow the state to track the number of children who have access to employment-based coverage and to ensure that children enrolling in the CHP+ are uninsured and are not dropping their employment-based coverage to enroll in the CHP+.

**Objective 4: To coordinate and consolidate with other health care programs providing services to children to create a seamless system for low-income children in need of health care.**

Performance goals under this objective will be based on enrollment from children previously receiving care through the Colorado Child Health Plan or the Colorado Indigent Care Program. Clients who enroll in either the Child Health Plan Plus or the Colorado Indigent Care Program will be tracked in an eligibility determination module that will interface with the Medicaid Management Information System allowing for coordination within the programs and with Medicaid. The Child Health Plan Plus eligibility system will also conduct Medicaid screening and will allow the state to track the number of children who were referred to Medicaid through the eligibility determination process. The Child Health Plan Plus will ask the Department of Health Care Policy and Financing to query Medicaid enrollment data to determine how many children referred from CHP+ to Medicaid have enrolled.

Objective **5**: Acquire contracts to provide statewide HMO coverage.

Performance goals under this objective will be measured by assessing whether at least one HMO provides coverage for CHP+ in each of the **63** Colorado counties. We will also assess whether HMOs are serving CHP+ members in the entirety of each HMO's licensed service area.

Check the applicable suggested performance measurements listed below that the state plans to use: (Section **2107(a)(4)**)

- 9.3.1. ☒ The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
- 9.3.2. ☒ The reduction in the percentage of uninsured children.
- 9.3.3. ☐ The increase in the percentage of children with a usual source of care.
- 9.3.4. ☒ The extent to which outcome measures show progress on one or more of the health problems identified by the state.
- 9.3.5. ☒ HEDIS Measurement Set relevant to children and adolescents younger than **19**.
- 9.3.6. ☐ Other child appropriate measurement set. List or describe the set used.
- 9.3.7. ☐ If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:
- 9.3.7.1. ☐ Immunizations
- 9.3.7.2. ☐ Well child care
- 9.3.7.3. ☐ Adolescent well visits
- 9.3.7.4. ☐ Satisfaction with care
- 9.3.7.5. ☐ Mental health
- 9.3.7.6. ☐ Dental care
- 9.3.7.7. ☐ Other, please list: \_\_\_\_\_
- 9.3.7.8. ☐ Performance measures ~~for~~ special targeted populations.
- 9.4. ☒ The state assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. (Section **2107(b)(1)**)

**9.5. ☒ The state assures it will comply with the annual assessment and evaluation required under Section 10.1. and 10.2. (See Section 10) Briefly describe the state's plan for these annual assessments and reports. (Section 2107(b)(2))**

The Colorado Department of Health Care Policy and Financing will perform the annual assessments and evaluations required in Section 2108(a). The Annual Report will include an assessment of the operation of the Child Health Plan Plus, its progress toward meeting its strategic objectives, and performance goals. The baseline number of uninsured children will be calculated from an average of the 1995, 1996, and 1997 March supplements to the Current Population Survey produced by the Bureau of the Census.

By March 31, 2000 the state will submit an evaluation that includes the following elements as specified in Section 2108(b).

- A. An assessment of the effectiveness of the CHP+ in increasing the number of children with creditable health coverage. One of the plan's strategic objectives is to decrease the proportion of low-income children in Colorado who are uninsured. The effectiveness of the plan in meeting this goal will be evaluated by examining the proportion of children in families with incomes  $\leq 185\%$  of the federal poverty level who are uninsured and the percentage of children who are income and asset eligible for Medicaid, who are enrolled in Medicaid. In addition, an estimate of the change in the proportion of children with incomes  $\leq 185\%$  who are covered under an employment-based plan to evaluate the extent that coverage provided under the plan does not substitute for coverage that would have been provided through an employer.
- B. A description and analysis of the effectiveness of the elements of this plan that will include, but are not limited to:
  - A. **Demographics.** The assessment will evaluate the characteristics of children covered under the CHP+ including age, family income, ethnicity, employment status of the child's parents, and access to other health insurance coverage, such as employment-based coverage, prior to enrolling in the CHP+.
  - B. **Quality** As described in section 7.1, quality will be measured through tools such as HEDIS, CAHPS, complaint data and quality improvement studies. HMOs and CHP+ contractors will use data from enrollment, claims and medical records to evaluate the effectiveness of care in the program. Effectiveness will be determined by the extent to which performance goals are met (see the five objectives under strategic objective one) and comparisons of CHP performance measures against benchmark standards (Medicaid and commercial performance) and community goals (Healthy People 2000).
  - C. **Subsidies and Cost-sharing.** Another strategic objective is to provide access to appropriate medical care to children in low-income families by reducing the financial barriers to affordable health care coverage. Therefore, the state will report the amount of subsidies paid out of state and federal funds, the amount

of cost-sharing paid in by enrollees, and the percentage of children who disenroll for financial reasons. This measure will also allow plan administration to determine families' compliance with cost sharing strictures.

- D. **Service area.** The analysis will include a description of the service area of the CHP+, and will address the ability of the state to acquire contracts to provide statewide HMO coverage.
  - E. **Time limits.** CHP+ enrollees will be guaranteed **12** months of eligibility, given that they meet their cost-sharing responsibilities. The evaluation will analyze how many children receive coverage for the full **12** months, and if not, will evaluate why coverage was dropped.
  - F. **Benefits Covered and other Methods Used to Provide Health Assistance.** The analysis will include a description of the benefits covered and other methods (if any) that the state used to provide health assistance.
  - G. **Sources of Non-Federal Funding.** The assessment will describe and detail sources of state and private funding used to cover the costs of the CHP+.
- C. **An** assessment of the effectiveness of other public and private programs in the state in increasing the availability of affordable quality individual and family health insurance for children.
- D. **A** review and assessment of State activities to coordinate the CHP+ with other public and private programs providing health care and health care financing, including Medicaid and maternal and child health services. **A** strategic objective of the plan is to coordinate and consolidate health care programs providing services to children. This assessment will evaluate the ability of the CHP+ to coordinate with Medicaid, the Colorado Indigent Care Program, the Colorado Child Health Plan, and other private programs.
- E. **An** analysis of changes and trends in the state that affect the provision of accessible, affordable, quality health insurance and health care to children. Trends that will be examined include changes in health care cost indexes, changes in state demographics and income, changes in the work status of parents and the level of unemployment, the level of HMO penetration across the state, and any new state legislation enacted subsequent to this plan that will affect children's health care.

- 9.6. ☒ **The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. (Section 2107(b)(3))**
- 9.7. ☒ **The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed.**

98. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title **XIX**: (Section 2107(e))

- 9.8.1. ☐ Section 1902(a)(4)(C) (relating to conflict of interest standards)
- 9.8.2. ☐ Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)
- 9.8.3. ☒ Section 1903(w) (relating to limitations on provider donations and taxes)
- 9.8.4. ☒ Section 1115 (relating to waiver authority)
- 9.8.5. ☒ Section 1116 (relating to administrative and judicial review), but only insofar as consistent with Title XXI
- 9.8.6. ☒ Section 1124 (relating to disclosure of ownership and related information)
- 9.8.7. ☒ Section 1126 (relating to disclosure of information about certain convicted individuals)
- 9.8.8. ☒ Section 1128A (relating to civil monetary penalties)
- 9.8.9. ☒ Section 1128B(d) (relating to criminal penalties for certain additional charges)
- 9.8.10. ☒ Section 1132 (relating to periods within which claims must be filed)

9.9. Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. (Section 2107(c))

Six working teams have been created to design the core elements of the Children's Basic Health Plan and to promote ongoing public input into the plan. The CBHP teams' recommended benefits and cost sharing have been applied to the CHP+ proposed in **this** Title XXI State Plan. The six teams are: 1) benefits design and pricing; 2) eligibility, enrollment, and management information system design; 3) financing; 4) marketing and outreach; 5) employer advisory group; and 6) contracting and quality assurance. These teams will continue to make recommendations to the Department of Health Care Policy and Financing concerning the design of the Children's Basic Health Plan. A Policy Board will review team recommendations and give strategic direction to the Department of Health Care Policy and Financing. The individuals who are members of these working teams have the opportunity to provide input into the development of the CBHP from the early stages of the decision-making process up to and beyond implementation. These working teams are

staffed and led by individuals representing the Department, the business community, the insurance industry, providers, children’s advocates, schools, employers, and other public and private programs providing services to children (See Attachment 8 for an implementation structure and Attachment 9 for team membership lists.)

**Benefits Design and Pricing.** This team is responsible for designing the benefit package and developing cost-sharing and subsidy structures. This team will develop price estimates for the benefit package under different cost sharing and subsidy structures scenarios. This team will recommend to the Department the benefit package and the subsidy level that will ensure an affordable product for low-income working families. Members of this team represent advocates for low-income families, the Colorado Division of Insurance, mental health providers, EPSDT outreach workers, providers of care to handicapped children, pediatricians, community health centers, and managed care organizations.

**Marketing and Outreach.** This team is responsible for developing a marketing plan and outreach strategy for partnering with schools, doctors’ offices, employers, social service providers, and public health entities throughout the state. This team will recommend to the Department the most effective outreach plan, materials design, and marketing strategy to ensure that eligible families are notified that this product is available and how they can apply. The team is developing a long term, phased plan for outreach and marketing of the CBHP. Not only will school systems be tapped, but the team, through its varied work in the community will be natural advocates and can also enlist volunteers who can advocate for the CBHP throughout the state. This team will recommend to the Department, the most effective outreach plan, materials design, and marketing strategy to ensure that eligible families are notified that this product is available and how to apply. Members of this team represent schools, day care centers, managed care organizations, providers, children’s advocacy groups, and the Colorado Child Health Plan (CCHP).

**Eligibility, Enrollment, and Management Information Systems Design.** This team is responsible for developing an eligibility and enrollment system that is flexible, simple to administer, and meets the long-term needs of the Children’s Basic Health Plan. This team will also be responsible for developing recommendations for the rules by which a child is deemed to be eligible for the program. Members of this team include representatives **from** managed care organizations, the Medicaid program in the Department of Health Care Policy and Financing, the Program for Children with Special Health Care Needs, Indian tribes, community health centers, the Colorado Child Health Plan, philanthropic provider clinics, and other providers.

**Financing.** This team is responsible for identifying funding streams available to finance the program, preparing budget projections, developing estimates of the number of children that will enroll, and creating mechanisms to ensure that the Children’s Basic Health Plan will be fiscally sound. Members of this team include representatives from community health centers, the Colorado Indigent Care Program,

the Office of State Planning and Budgeting, the Colorado Child Health Plan, and the Department of Health Care Policy and Financing's budget and accounting offices.

**Employer Advisory Group.** This team will present recommendations to the Department regarding mechanisms to ensure that the Children's Basic Health Plan does not become a substitute for employer-based coverage. This group will establish a means for the Department and employers to coordinate coverage for children eligible for the program, create incentives for employers to assist the Department with outreach and eligibility determination, and present recommendations as to how the subsidy can be structured to ensure that employees do not drop employer-based coverage. Membership of this team represents a broad base of employers and business organizations such as US West, Kodak, and Mile Hi Child Care Centers.

**Contracting and Quality Assurance:** This team is responsible for developing purchasing strategies and contract standards for the CHP+ program. The team will decide how HMO contracts will be awarded, how HMO premiums will be determined, what requirements will be in the HMO contract and what quality information will be reported by the CHP+ plans. The team will review options for purchasing, pricing and quality assurance from Medicaid and commercial models. The team membership is currently being developed. Members of the team will include health plans, physicians, hospitals, clinics, consumers and state agency staff.

**Policy Board:** The Policy Board will review key team recommendations and give strategic guidance to the Department of Health Care Policy and Financing in the design and implementation of the Children's Basic Health Plan. This group comprises high-level private sector business managers, hospitals, providers, children's advocates, the insurance industry, the General Assembly, the Colorado Department of Public Health and Environment, and the Colorado Division of Insurance. This group will convene on a monthly basis to review the progress of the Working Teams and to address any issues brought forward by the Working Teams. Once the second phase of the State Plan is developed, the Policy Board will be responsible for reviewing the plan and briefing stakeholders, constituents, and other members of the community on the intent and content of the proposal.

The Department of Health Care Policy and Financing is committed to allowing the public as many opportunities as possible to provide input into the development of this program. In addition to the methods described above, Department staff responsible for developing the state plan will have ongoing meetings to solicit input from stakeholders on the design of the Children's Basic Health Plan. Staff will continue to have ad hoc meetings with a variety of interested parties and to mail updates of the planning process in a newsletter mailed to 5,000 Coloradans who have expressed an interest in state health care policy issues. Staff continues to identify people and share information with people who are interested in knowing more about the Children's Basic Health Plan.

**9.10. Provide a budget for this program. Include details on the planned use of funds and sources of the non-Federal share of plan expenditures. (Section 2107(d))**

## ADMINISTRATIVE COSTS (INCLUDING MARKETING/OUTREACH)

In the first years of implementation, administrative costs exceed the amount that can be used for federal match. Excess administrative costs will be covered with state-only funds.

Child Health Plan Plus Administrative Budget SFY98-00				
I. Personnel	FY98	FY99	FY00	
MARKETING	\$ 56,804	\$ 214,394	\$ 225,114	
ELIGIBILITY	\$ 76,948	\$ 235,212	\$ 246,973	
SYSTEMS ADMINISTRATION	\$ 53,969	\$ 122,298	\$ 128,413	
GENERAL ADMINISTRATIVE	\$ 88,083	\$ 288,473	\$ 302,897	
<i>Subtotal</i>	<i>\$ 275,804</i>	<i>\$ 860,377</i>	<i>\$ 903,396</i>	
II. Other Direct Costs				
GENERAL OPERATIONS	\$ 40,224	\$ 120,070	\$ 138,080	
MARKETING/OUTREACH	\$ 102,861	\$ 353,105	\$ 683,680	
<i>Subtotal</i>	<i>\$ 143,084</i>	<i>\$ 473,174</i>	<i>\$ 821,760</i>	
III. Indirect Costs	\$ 13,662	\$ 106,684	\$ 138,013	
IV. Equipment and Computer Systems				
SERVER	\$ 38,000	\$ -	\$ -	
SIDMOD MODULE	\$ 100,000	\$ -	\$ -	
MMIS MODIFICATIONS	\$ 239,800	\$ -	\$ -	
PCS	\$ 6,000	\$ -	\$ -	
<i>Subtotal</i>	<i>\$ 383,800</i>	<i>\$ -</i>	<i>\$ -</i>	
V. Contract Agreements				
COMPUTER CONSULTANTS	\$ 25,000	\$ -	\$ -	
PREMIUM PROCESSING	\$ -	\$ 490,542	\$ 1,056,484	
ENROLLMENT BROKER	\$ -	\$ 171,002	\$ 368,288	
LEGAL	\$ -	\$ 3,084	\$ 3,084	
AUDIT	\$ 5,000	\$ 5,500	\$ 6,050	
MARKETING CONSULTANTS	\$ 75,000	\$ 40,000	\$ 54,000	
<i>Subtotal</i>	<i>\$ 105,000</i>	<i>\$ 710,128</i>	<i>\$ 1,487,901</i>	
Total	\$ 921,351	\$ 2,150,364	\$ 3,351,075	

Proposed Effective Date: 1/1/98

I. Personnel

**Marketing and Outreach.** Marketing will be conducted by existing Colorado Child Health Plan staff. Staff will conduct local meetings to provide information about the Colorado Child Health Plan Plus, to gauge community interest in implementing the program, and to offer technical assistance to schools, providers, and employers interested in helping market the program.

**Eligibility Determination and Enrollment.** Estimated costs are based on current costs for application processing, eligibility determination, premium collections (January 1, 1998 to June 30, 1998 only), and enrollment as conducted by current Colorado Child Health Plan staff.

**Systems Administration.** The CHP+ will hire staff to administer the CHP+ eligibility system. Staff will be responsible for designing the system architecture, developing the production system, managing the implementation of the production system, and conducting ongoing systems support including backup and recovery of data, login ID support, application/rules changes, etc.

**General Administrative.** Existing CHP staff will conduct the day-to-day operations of the CHP+.

11. Direct Costs

**General Operations.** Operating costs include equipment maintenance and repair, in-state travel, office supplies, postage, printing, telephone maintenance, and toll charges.

**Marketing and Outreach.** Marketing and outreach costs include printing, duplication, and handling of marketing and enrollment materials, phone charges, and travel expenses.

111. Indirect Costs

Indirect costs for SFY98 are calculated based on the number of additional staff that the CHP+ will hire in order to implement the CHP+. It is assumed that in SFY98 all other indirect costs are in the CHP+ base budget which are not included here. Beginning with SFY99, indirect costs are assumed to be 8% of total Personnel and Direct costs.

#### IV. Equipment and Computer Systems

**Server.** A server will be purchased to support the development of remote eligibility determination and the conversion of the existing [CHP] Access database to SQL Server. This server will be a designated development system used for the prototyping of new applications for the CHP+.

**Development of a State Identification Module (SIDMOD).** A contractor will be hired to develop a module to assign CHP+ clients a state identification number to ensure that a child is not simultaneously enrolled in Medicaid and the CHP+. Development costs are estimated to be **\$100,000**.

**Modifications to the Medicaid Management Information System (MMIS) to allow for premium processing.** The Medicaid MMIS will be expanded so that beginning July 1, 1998, it can pay capitation rates to HMOs, generate premium invoices and follow-up notices to enrollees, and produce an interface file to the enrollment broker of delinquent payers for potential disenrollment. Development costs are estimated to be approximately **\$239,800**.

**Personal Computers (PCs).** To accompany increased staff, the CHP+ will need to purchase two additional personal computers at a cost of approximately \$6,000.

#### V. Contractual Agreements

**Computer Consultants.** A computer programmer will be hired to design a rules-based eligibility determination system for the Child Health Plan Plus and the Colorado Indigent Care Program. It is estimated that in SFY98 this will cost **\$25,000**.

**Premium Processing.** No additional marginal cost for premium collection are assumed prior to July 1, 1998 since premiums will be collected by existing CCHP staff. Beginning on or after July 1, 1998 the Child Health Plan Plus will contract for premium processing services. This contractor will generate and mail monthly invoices, and will process payments as they are received. Estimated costs are **\$3.82** per enrollee per month.

**Enrollment Broker.** Beginning on or after July 1, 1998 the Child Health Plan Plus may use an enrollment broker to inform clients of the managed care plans in which they can enroll. This informing process will take place by phone and mail. The managed care plans serving this new population will also serve the Medicaid population. Therefore, a common enrollment broker will be used by this program and the Medicaid program to inform clients of their health care options and enroll them with a plan. Only the marginal costs of informing and enrolling this new population are shown because the base costs of the enrollment broker are borne by the Medicaid program. Other states that have contracted for brokers pay the equivalent of a

transaction fee. It is assumed that the transaction fee is **\$33** per family. Included in the per transaction fees are contractor staff salaries and overhead expenses such as equipment, software development and maintenance, other computer programming resources, graphic design and printing of information materials, postage, etc.

**Legal.** It is estimated that the CHP+ will incur legal costs in the amount of **\$3,084** each year, beginning in **SFY99**.

**Audit.** The Child Health Plan Plus may be required to submit financial and performance audits.

**Marketing Consultants.** Consultants will design a logo and images that will be associated with the CHP+, will develop and print brochures and applications, will purchase limited radio, TV, and newspaper advertising, and will develop press releases, media briefings, stories in publications, radio and TV interviews.

**BENEFIT COSTS**

Enrollment projections are based on current estimates of funds earmarked for the CHP+. If the state decides to appropriate additional general funds or receives private funding, enrollment levels will be higher. The benefits costs shown below are **only** for the comprehensiveCHP+ health care benefits. The costs of enrollment in the outpatient Colorado Child Health Plan are not included in Colorado’s state plan at this time.

Colorado Child Health Plan Plus Benefit Budget SFY98-00			
	Average Monthly Enrollment	Annual Per Capita Cost	Total Cost
<b>SFY 97-98</b>			
Infants	71	\$1,427	\$101,970
1-5 Year Olds	2,913	\$286	\$831,852
6-12 Year Olds	3,945	\$227	\$895,857
13-17 Year Olds	1,635	\$433	\$707,757
Total	8,564		\$2,537,436
<b>SFY98-99</b>			
Infants	89	\$2,855	\$253,673
1-5 Year Olds	3,494	\$571	\$1,995,317
6-12 Year Olds	4,745	\$454	\$2,154,800
13-17 Year Olds	2,374	\$866	\$2,055,567
Total	10,701		\$6,459,357
<b>SFY99-00</b>			
Infants	220	\$2,997	\$660,747
1-5 Year Olds	7,392	\$600	\$4,432,549
6-12 Year Olds	10,186	\$477	\$4,857,096
13-17 Year Olds	5,249	\$909	\$4,772,837
Total	23,047		\$14,723,229

SOURCES OF NON-FEDERAL SHARE OF EXPENDITURES

The Child Health Plan Plus operations will be funded from three primary sources: state General Fund, CHP cash reserves, and donations. The following paragraphs describe the origin and amount of each of these funding sources.

Colorado Child Health Plan Plus			
Sources of Non-Federal Funding SFY98-00			
	SFY97-98	SFY98-99	SFY99-0
Medicaid Managed Care Savings	\$ -	\$1,196,881	\$6,570,01
CHP General Fund appropriation	\$1,013,598	\$1,013,598	\$1,01339
One-time General Fund appropriation	\$2,000,000	\$ -	\$ .
Private Grants	\$225,000	\$110,676	\$
University Hospital donation	\$650,000	\$650,000	\$ 650,00
CHP Cash Reserves	\$1,970,482	\$ -	\$
Total State and Private Funding Available	\$5,859,080	\$2,971,155	\$8,233,61
Less state-only expenditures for children receiving non-comprehensive benefits	(\$2,796,406)	(\$588,954)	\$
Less carryover of funding in Trust	(\$1,400,000)	\$1,400,000	\$
Total Non-Federal Funding	\$1,662,674	\$3,782,201	\$8,233,61

State General Fund

Medicaid Managed Care Savings

The state law (C.R.S. 26-4-113(7)(c)) expresses the intent that a portion of the general fund share of the savings realized from increased enrollment of Medicaid clients into managed care be appropriated to the Children’s Basic Health Plan. Medicaid clients who enroll in managed care choose between the Primary Care Physician Program (PCP) and Health Maintenance Organizations (HMOs). HMOs are paid a capitated rate which the Department sets at 95% of fee-for service costs. In other words, for each client enrolled in an HMO, the Department realizes a 5% per capita savings.

Colorado Child Health Plan State General Fund Appropriation

The Colorado Child Health Plan currently receives a state General Fund appropriation of \$1,013,598.

One-time General Fund Appropriation

House Bill 97-1304 created the Children’s Basic Health Plan Trust and included a one-time \$2 million General Fund to the Trust to fund the expansion of the Colorado Child Health Plan and the start-up costs of the Children’s Basic Health Plan. Enrollment is limited below available funding in SFY97-98 to allow funds to be carried over to SFY98-

99 to maintain SFY98-99 enrollment levels. In general, any unspent funds held in the Trust do not revert back to the General Fund at the end of the state fiscal year and can be carried forward to be spent in future years.

Donations

*University Hospital*

University Hospital contributes a donation in the amount of \$650,000 to the Colorado Child Health Plan each year.

*Private Foundations*

Local foundations have contributed \$225,000 in private funds to support the start-up costs of the Children’s Basic Health Plan. These commitments include \$90,000 from the Colorado Foundation, \$20,000 from the Piton Foundation, \$25,000 from the Denver Foundation, \$40,000 from the Blue Cross/Blue Shield Foundation, and \$50,000 from the Rose Foundation. In addition, the Department of Health Care Policy and Financing has applied for \$110,676 under the Robert Wood Johnson’s Healthy Kids Replication Program.

Colorado Child Health Plan Cash Reserves

At the beginning of SFY97-98, the Colorado Child Health Plan held \$1,970,482 in cash reserves. This reserve includes University Hospital donations made to the CHP that could not be spent in previous years.

**PREMIUM COLLECTIONS**

The state does not anticipate collections of premiums until July 1, 1998. The state is currently developing a system to accommodate premium collection and processing. **Prior** to July 1, 1998, premiums will be collected as existing CHP+ staff resources allow. Premiums that the state is able to collect prior to July 1, 1998, will be offset against payments for benefits for matching purposes.

Colorado Child Health Plan Plus Estimated Premium Collections						
SFY 98-99						
Income Level	Distribution	Number of Enrollees	Number of Families	Per Family Premium	Months	Total Premiums
up to 40%	3.34%	357	161	\$ -	12	\$
41-62%	6.26%	670	302	\$ -	12	\$
63-81%	9.32%	997	449	\$ 5	12	\$ 26,955
82-100%	11.96%	1,280	577	\$ 10	12	\$ 69,182
101-117%	13.96%	1,494	673	\$ 15	12	\$ 121,126
118-133%	13.32%	1,425	642	\$ 15	12	\$ 115,573
134-159%	21.70%	2,322	1,046	\$ 15	12	\$ 188,283
160-185%	19.07%	2,041	919	\$ 25	12	\$ 275,772
Other	1.07%	115	52	\$ -	12	\$
Total	100.00%	10,701	4,820			\$ 796,891
SFY 99-00						
Income Level	Distribution	Number of Enrollees	Number of Families	Per Family Premium	Months	Total Premium
up to 40%	3.34%	770	347	\$ -	12	\$ -
41-62%	6.26%	1,443	650	\$ -	12	\$
63-81%	9.32%	2,148	968	\$ 5	12	\$ 58,054
82-100%	11.96%	2,756	1,242	\$ 10	12	\$ 148,997
101-117%	13.96%	3,217	1,449	\$ 15	12	\$ 260,869
118-133%	13.32%	3,070	1,383	\$ 15	12	\$ 248,910
134-159%	21.70%	5,001	2,253	\$ 15	12	\$ 405,506
160-185%	19.07%	4,395	1,980	\$ 25	12	\$ 593,933
Other	1.07%	247	111	\$ -	12	\$
Total	100.00%	23,047	10,382			\$ 1,716,265

SUMMARY BUDGET

Following is a *summary* budget with estimated state and federal share of spending for SFY 98-00.

Enrollment in SFY97-98 and SFY98-99 is limited to remain within available state-level funding. In SFY99-00 state-level funding exceeds what is required to cover the costs of expected enrollment levels. In this case, SFY99-00 excess funding will be carried forward to cover costs in SFY00-01.

Child Health Plan Plus Summary Budget SFY98-00						
	Total	State Only Expenditures	Matchable Expenditures	State Match	Federal Match	
SFY97-98: January 1,1998 -June 30,1998						
Administrative Costs	\$ 921,351	\$ 740,821	\$ 180,530	\$ 60,620	\$ 119,910	
Benefit Costs	\$ 2,537,436	\$ -	\$ 2,537,436	\$ 852,046	\$ 1,685,390	
Total	\$ 3,458,787	\$ 740,821	\$ 2,717,966	\$ 912,666	\$ 1,805,300	
SFY98-99: July 1, 1998-June 30,1999						
Administrative Costs	\$ 2,150,364	\$ 1,747,498	\$ 402,865	\$ 135,278	\$ 267,587	
Net Matchable Benefit Costs	\$ 5,662,467	\$ -	\$ 5,662,467	\$ 1,901,400	\$ 3,761,067	
Gross Program Costs	\$ 6,459,357					
Enrollee Premium Cost Sharing	\$ (796,891)					
Total	\$ 7,812,830	\$ 1,747,498	\$ 6,065,332	\$ 2,036,678	\$ 4,028,654	
SFY99-00: July 1,1999 - June 30,2000						
Administrative Costs	\$ 3,351,075	\$ 2,425,674	\$ 925,401	\$ 310,741	\$ 614,661	
Net Matchable Benefit Costs	\$ 13,006,960	\$ -	\$ 13,006,960	\$ 4,367,607	\$ 8,639,353	
Gross Program Costs	\$ 14,723,229					
Enrollee Premium Cost Sharing	\$ (1,716,269)					
Total	\$ 16,358,035	\$ 2,425,674	\$ 13,932,361	\$ 4,678,348	\$ 9,254,014	

Section **10.** Annual Reports and Evaluations (section 2108)

**10.1.** Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: (Section 2108(a)(1),(2))

**10.1.1.** ☒ The progress made in reducing the number of uncovered low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

**10.1.2.** ☒ Report to the Secretary, January 1 following the end of the fiscal year, on the result of the assessment.

**10.2.** ☐ State Evaluations. The state assures that by March **31,2000** it will submit to the Secretary an evaluation of each of the items described and listed below: (Section 2108(b)(A)-(H))

**10.2.1.** ☒ An assessment of the effectiveness of the state plan in increasing the number of children with creditable health coverage.

**10.2.2.** ☒ A description and analysis of the effectiveness of elements of the state plan, including:

**10.2.2.1.** ☒ The characteristics of the children and families assisted under the state plan including age of the children, family income, and the assisted child's access to or coverage by other health insurance prior to the state plan and after eligibility for the state plan ends;

**10.2.2.2.** ☒ The quality of health coverage provided including the types of benefits provided;

**10.2.2.3.** ☒ The amount and level (including payment of part or all of any premium) of assistance provided by the state;

**10.2.2.4.** ☒ The service area of the state plan;

**10.2.2.5.** ☒ The time limits for coverage of a child under the state plan;

**10.2.2.6.** ☒ The state's choice of health benefits coverage and other methods used for providing child health assistance, and

**10.2.2.7.** ☒ The sources of non-Federal funding used in the state plan.

**10.2.3.** ☒ An assessment of the effectiveness of other public and private programs in the state in increasing the availability of affordable quality individual and family health insurance for children.

- 10.2.4. ☒ A review and assessment of state activities to coordinate the plan under this Title with other public and private programs providing health care and health care financing, including Medicaid and maternal and child health services.
- 10.2.5. ☒ An analysis of changes and trends in the state that affect the provision of accessible, affordable, quality health insurance and health care to children.
- 10.2.6. ☒ A description of any plans the state has for improving the availability of health insurance and health care for children.
- 10.2.7. ☐ Recommendations for improving the program under this Title.
- 10.2.8. ☒ Any other matters the state and the Secretary consider appropriate.
- 10.3. ☒ The state assures it will comply with future reporting requirements as they are developed.
- 10.4. ☒ The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

## Glossary

### **Child Health Plan Plus (CHP+)**

Child Health Plan Plus (CHP+) is the subsidized health insurance program delivering comprehensive benefits through HMOs to children age 0 through 17 in families with incomes at or below 185% FPL. The Child Health Plan Plus will be implemented January 1, 1998 as the first phase of Colorado's Title XXI program.

### **Children's Basic Health Plan (CBHP)**

The Children's Basic Health Plan (CBHP) is the subsidized health insurance program authorized by House Bill 97-1304 for children ages 0 through 17 in families with incomes at or below 185% FPL. The Children's Basic Health Plan will include implementation of a rules-based eligibility system, a more sophisticated collections and HMO payment system, and an enhanced managed care quality oversight system as compared to the Child Health Plan Plus. The overall program is guided by the Children's Basic Health Plan Policy Board. The CBHP is the second phase of Colorado's Title XXI program. Colorado will submit the necessary amendments or waivers to this State Plan to implement phase two of the Children's Basic Health Plan.

### **Colorado Child Health Plan (CCHP):**

The Colorado Child Health Plan (CCHP), administered through the University of Colorado Health Sciences Center, is legislatively established as a community-based health care reimbursement plan for low-income children under the age of eighteen. The plan provides outpatient medical care to children from families whose incomes place them at or below 185% of the Federal Poverty Level. Children eligible for Medicaid are not eligible for the Colorado Child Health Plan. As of June 30, 1997, the Colorado Child Health Plan had enrolled 7,003 children under 13 from 54 Colorado counties. By virtue of the passage of Colorado House Bill 1304, the plan became available to children 0 through 17 in all 63 Colorado counties. As of August 31, 1997, the plan had enrolled 9,482 children including members from all 63 counties up to age 18.

### **The Health Care Program for Children with Special Needs (HCP)**

The Health Care Program for Children with Special Needs (HCP) is a joint state/federal program administered by the Colorado Department of Public Health and Environment for children age 20 and under who have a physical disability that interferes with normal growth and development. HCP helps pay medical bills and provides follow-up for children diagnosed with a clinically qualifying handicapping condition. Examples of covered conditions include cerebral palsy, cystic fibrosis, seizures, heart defects, hearing loss, and cleft lip and palate. The program also provides diagnostic services for all financially qualified children suspected of having a disability or chronic heart condition. Children with conditions eligible for the program are identified through county nursing services, health care providers, Child Find coordinators in public schools, and local Early Childhood Connections staff. Currently, about 5,000 children are enrolled in HCP statewide.

**Colorado Benefits Management System (CBMS)**

**An** integrated eligibility determination system for medical assistance programs including Medicaid and the Children’s Basic Health Plan. The project, co-managed by the Department of Human Services and the Department of Health Care Policy and Financing, will be implemented July, 2000.

**Colorado Indigent Care Program (CICP)**

The Colorado Indigent Care Program (CICP), administered by the Colorado Department of Health Care Policy and Financing, is a state and federally funded provider reimbursement program that discounts the cost of medical care at its participating health facilities for adults **as** well as children. If a person is eligible for Medicaid, he or she is ineligible for CICP. Covered services vary by participating hospitals or clinics, but generally include hospital costs such as inpatient stays, surgery, and prescription drugs. All children deemed eligible for the heretofore mentioned programs are directed towards them immediately at CICP-participating providers.

**Colorado Uninsurable Health Insurance Plan (CUHIP)**

Colorado Uninsurable Health Insurance Plan (CUHIP) was established in 1990 by the Colorado General Assembly as a quasi-governmental entity to provide health insurance to individuals, including children, who are denied health insurance by private carriers because of a pre-existing medical condition. People who are eligible for Medicaid or Medicare cannot enroll in this program. Only eight people, or one percent of those CUHIP members who disenrolled from the plan in 1996, did so because they became eligible for Medicaid. The plan is financed with funds from the state Business Association Unclaimed Property Fund. CUHIP provides an important source of insurance to children who are considered uninsurable. However, CUHIP rates (currently **130%** of standard plan) are often out of reach for low-income families. CUHIP conducts an ongoing multi-media public awareness campaign to reach out to underserved markets across the state. Priority audiences include potential referral sources such as physicians, clinical social workers, financial planners, insurance agents and brokers.

**Commodity Supplemental Food Program (CSFP)**

The Commodity Supplemental Food Program distributes United States Department of Agriculture food commodities to eligible low-income residents of Conejos, Costilla, Denver, Mesa, Rio Grande and Weld counties in Colorado. The program provides infant formula and nutritious foods to supplement the diet of pregnant and postpartum women (up to 12 months after delivery) and children under age six.

**Community Health Centers**

Community health centers offer a wide range of health care to people who may need some financial assistance with their medical bills. Colorado has 15 community health centers with more than 50 clinic sites in medically underserved areas of the state. Community health centers provide comprehensive primary care services including care for acute and chronic illness, injuries, family planning and prenatal care, emergency care, diagnostics services and prescriptions.

### **Maternal and Child Health or Title V of the Social Security Act**

Maternal and Child Health or Title V of the Social Security Act funds in Colorado are “passed through” to local public health agencies and other qualified non-profit agencies where they are used to support a number of activities on behalf of women and children, particularly those of low income. State Title V staff provide oversight, consultation and standards to assure appropriate utilization of these funds. When families are ineligible for any insurance plan, or when there is not another provider of free or reduced price health care (i.e. community or rural health centers) available or accessible, these public health agencies often serve as the “safety net” provider for low income children, particularly those under **185%** of FPL. Services provided in local public health agencies are almost always provided by public health nurses. Services include comprehensive well child clinic services, including developmental and physical assessments, immunizations, and parent education. Families under **100%** FPL pay nothing for these services. Others pay on a sliding fee scale.

### **Pian**

The Plan refers to Child Health Plan Plus.

### **School-Based Health Centers (SBHCs)**

School-based health centers provide comprehensive primary care services including care for acute and chronic illness, injuries, family planning and prenatal care, some diagnostics services and prescriptions. SBHCs provide services at no charge. However, patients are asked about coverage they may have. The degree to which the SBHCs bill for reimbursement depends on the administrative capabilities of the center. SBHCs facilitate application to Medicaid, CCHP or CICP when documentation of family income and assets is obtainable without jeopardizing students’ confidentiality.

### **The Special Nutritional Program for Women, Infants and Children (WIC)**

The Special Nutritional Program for Women, Infants and Children (WIC) provides nutritious food to supplement the regular diet of pregnant women, breast-feeding women, infants, and children under age five who meet state income standards. Children under five years old qualify if the combined family income is at or below **185%** of the federal poverty level.

### **Safety Net Providers**

A safety net provider is a health care provider that has historically served medically needy or medically indigent patients who make up a significant portion of its patient population and waives charges for services on a sliding scale based on income and does not restrict access or services because of a client’s financial limitations. Examples of safety net providers include Federally Qualified Health Centers (FQHCs), Disproportionate Share Hospitals (DSH), family planning clinics, and school-based health centers.

Attachment 1:  
Colorado Standard Plan Benefit Package

The Colorado Standard Health Plan, deemed as the general standard benefit package in Colorado, as approved by the Colorado Department of Regulatory Agencies Division of Insurance covers the following items:

Benefit	COPAYMENTS
1. HOSPITAL AND EMERGENCY ROOM TRANSPORT	\$50 copay/visit (including emergency transport) <sup>1</sup>
2. INPATIENT	\$100 per admission
3. OUTPATIENT MAJOR SURGERY	\$100 per surgery
4. MEDICAL OFFICE VISIT (including physician, mid-level practitioner, & specialist visits)	\$10 copay/visit
5. LABORATORY & X-RAY SERVICES	No copay for preventive services
6. PREVENTIVE CARE	\$10 copay/visit
7. INFANT & PREGNANT CARE  Prenatal   Deliver & inpatient well baby care	\$10/visit; no copay for procedure ordered by physician  \$100 copay/admission
8. PSYCHIATRICALLY-BASED MENTAL ILLNESS (EFFECTIVE 1/1/98)	Treated the same as any other condition (\$10/office visit; \$100 copay/admission)
9. ALL OTHER MENTAL HEALTH Institutional care (Maximum 45 inpatient or 90 partial days/year)  Outpatient care	50% <sup>6</sup>  20 visits or \$1,500/year maximum

<sup>1</sup> Pursuant to Colorado Insurance Regulation 4-2-17, a carrier cannot deny a claim for emergency services necessary to screen and stabilize a covered person on the grounds that an emergency medical condition did not actually exist if a prudent layperson having an average knowledge of health services and medicine acting responsibly would have believed that an emergency medical condition or life or limb threatening condition existed. Non-emergency care delivered in an emergency room and ambulance service for non-emergency care are covered only if the covered person receiving such care was referred by the carrier or their primary care physician to the emergency room for care or was authorized by the carrier or their primary care physician to order an ambulance. If emergency rooms are used by the plan as a medical office/clinic, then office/clinic copays apply.

<sup>2</sup> Inpatient care includes all physician, surgical, and other services delivered during a hospital stay.

<sup>3</sup> Includes low dose mammography screening not otherwise covered under the list of preventive care services, as mandated by Colorado law, Section 10-16-104(4), C.R.S.

<sup>4</sup> Well baby care includes an in-hospital newborn pediatric visit.

<sup>5</sup> Requires the following to be treated as any other illness or condition: schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive compulsive disorder, and panic disorder. Applies to all group health benefit plans.

<sup>6</sup> Pursuant to section 10-8-606(2), C.R.S., the following small employers may exclude mental health coverage from their plans: any small employer who has not provided group sickness and accident insurance to employees after July 1, 1989, and any small employer who has provided group sickness and accident from a person or entity licensed pursuant to section 10-3-903.5, C.R.S., that did not include mental

Benefit	COPAYMENTS
10. ALCOHOL & SUBSTANCE ABUSE	Diagnosis, medical treatment, & referral services. Covered <b>50%</b> . <sup>8</sup>
11. PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY	\$10/visit <sup>9</sup>
12. DURABLE MEDICAL EQUIPMENT	50%. Maximum \$800/year paid by plan. Includes home oxygen." <sup>10</sup>
13. ORGAN TRANSPLANTS	\$100/admission copay <sup>11</sup>
14. HOME HEALTH CARE	Covered in full.
15. HOSPICE CARE	Covered in full.
16. OUTPATIENT PRESCRIPTION DRUGS	<b>\$5</b> copay generic; \$10 copay brand name
17. SKILLED NURSING FACILITY CARE	\$50 copay/day <sup>12</sup>

health coverage after July 1, 1989. However, carriers allowing for such an exclusion must follow all the relevant provision of 10-16-105(2), C.R.S., relating to such an exclusion.

<sup>7</sup> The per day cost of residential care must be less than or equal to the cost of a partial day of hospitalization. Each two days of residential or partial hospital care counts as one day of inpatient care.

<sup>8</sup> Carriers shall also offer alcoholism coverage pursuant to Section 10-16-104(9), C.R.S., as may be amended. HMOs shall comply with the alcohol and drug abuse benefit for federally qualified HMOs pursuant to 42 C.F.R., Section 417.101(a)(5).

<sup>9</sup> Coverage for medically necessary therapeutic treatment only. Benefits will not be paid for maintenance therapy after maximum medical improvement is achieved.

<sup>10</sup> Coverage for lesser of purchase price or rental price for medically necessary durable medical equipment, including home administered oxygen.

<sup>11</sup> Covered transplants include liver, heart, heart/lung, cornea, kidney, and bone marrow for aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and stage III breast cancer, and Wiskott Aldrich syndrome only. Peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants. Transplants will be covered only if the are medically necessary and the facility meets clinical standards for the procedure.

<sup>12</sup> Care must follow a hospital confinement and the skilled nursing facility confinement must be the result of an injury or sickness that was the cause of the hospital confinement. Benefits will not be paid for custodial care or maintenance care or when maximum medical improvement is achieved and no further significant measurable improvement can be anticipated.

Benefit	COPAYMENTS
18. EXCLUSIONS	Cosmetic care, war, care not medically necessary; treatment for work-related illnesses and injuries except for those individuals who are not required to maintain or be covered by workers' compensation insurance as defined by workers' compensation laws <sup>13</sup> , non-fault auto, or employers liability laws, marital or social counseling, educational training problems, learning disorders, transplants except those listed, dental care except accidents, TMJ (except that TMJ that has a medical basis is covered), experimental/investigational procedures, infertility treatment and counseling except as specifically otherwise covered in the policy requirements of this plan, hearing aids and fitting, eye glasses and contact lenses, nursing home care except as specifically otherwise covered in this plan, and custodial care.

There are no limitations for pre-existing conditions. A pre-existing condition is defined as an injury, sickness, or pregnancy for which a person incurred charges, received medical treatment, consulted a health care professional, or took prescription drugs within six months immediately preceding the effective date of coverage.

There is no coverage for dentistry, vision services and audiology. There is no lifetime maximum and no annual deductible.

<sup>13</sup> Except that, if a workers' compensation policy is in place (although not required by state labor law), the workers' compensation policy, not this plan, is responsible for medical benefits for work-related illnesses and injuries. In addition, if this plan is a federally qualified HMO plan, proof of workers' compensation coverage, if such coverage is required by law, may be required as a condition of coverage if such proof is required on the HMO's other small employee plans.

Attachment 2:  
Colorado Children by Income, Race/Ethnicity,  
and Health Insurance Coverage Status

% FPL	0-41%	42-100%	101-133%	134-185%	186-200%	201-250%	251+%	Row Totals
Medicare	36	35	42	0	0	0	0	113
Employer-based and Medicaid	491	1,279	717	602	424	0	73	3,586
Employer-based	4,841	7,612	7,428	40,230	2,122	40,574	87,912	200,719
Medicaid	25,052	32,078	5,463	7,335	629	905	1,393	72,855
Private, Nongroup	0	2,547	0	3,401	0	2,990	14,841	23,779
Uninsured	1,735	13,691	8,636	11,181	880	6,635	8,921	51,679
Column Totals	32,155	57,242	22,286	62,749	4,055	51,104	123,140	352,731

% FPL	0-41%	42-100%	101-133%	134-185%	186-200%	201-250%	251+%	Row Totals
Medicare	42	1,714	366	0	0	0	0	2,122
Employer-based and Medicaid	0	879	37	0	0	0	184	1,100
Employer-based	1,222	9,887	13,824	39,696	8,546	48,197	220,833	342,205
Medicaid	21,057	22,166	1,664	2,722	0	423	1,934	49,966
Private, Nongroup	0	6,197	0	6,428	0	6,929	26,753	46,307
Uninsured	4,864	19,252	13,161	16,425	1,597	13,637	12,516	81,452
Column Totals	27,185	60,095	29,052	65,271	10,143	69,186	262,220	523,152

Children in Colorado Age 15 through 18 by Income and Coverage Status								
Yo FPL	0-41%	42-100%	101-133%	134-185%	186-200%	201-250%	251+%	Row Totals
Medicare	36	0	0	0	0	0	0	36
Employer-based and Medicaid	0	457	366	0	0	0	0	823
Employer-based	325	5,998	8,199	7,739	1,911	20,786	89,096	134,054
Medicaid	2,561	3,734	1,407	187	0	0	906	8,794
Private, Nongroup	462	0	0	2,077	0	2,176	11,032	15,747
Uninsured	4,408	4,686	2,914	6,132	247	3,977	5,871	28,235
Column Totals	7,792	14,875	12,886	16,135	2,158	26,939	106,905	187,690

Children in Colorado Age 0 through 18 by Race / Ethnicity and Coverage Status							
	White	Black	Hispanic	Native American	Alaska Native	Asian Pacific Islander	Row Totals
Medicare	479	36	1,756	0	0	0	2,271
Employer-based and Medicaid	2,217	0	3,256	0	0	35	5,508
Employer-based	553,143	27,397	79,173	1,842	0	15,422	676,977
Medicaid	65,357	8,100	54,934	2,772	96	357	131,616
Private, Non-group	71,946	0	4,757	4,279	0	4,851	85,833
Uninsured	100,524	6,816	50,989	1,880	48	1,09	161,366
Column Totals	793,667	4,248	194,865	10,773	144	21,773	1,063,571

Source: RAND Corporation Survey funded by the Robert Wood Johnson Foundation, 1993

**Attachment 3:**  
**Family Size and Income Criteria**

The Child Health Plan Plus will use the Colorado Child Health Plan’s family size and income verification process described below. These criteria are applied as described in Section **4.3** of this State Plan.

**Family Size**

The eligibility system defines a “family” as an economic unit. The following information helps technicians determine if a family member can be counted in family size.

To be counted in family size, family members must receive at least 50% of their support from the family unit.

Family members can include:

Spouses (including common-law marriage)	Children	Stepchildren
Adopted children	Unborn children	Grandchildren
Step-grandchildren	Parents	Step-parents
Parents-in-law	Grandparents	Brothers and sisters
Brothers-in-law and sisters-in-law	Sons-in-law and daughters-in-law .	

Family members cannot include:

✓ **Emancipated Minors**  
Emancipated minor means a person under **18** years of age but over 15 years of age, living separate from their parent or guardian, with or without consent, who is financially independent. “Emancipated”can also mean a person under **18** years of age who is legally married.

✓ **Family Members Outside of Colorado**

If a family member lives outside of Colorado, the member counts in family size only if the family provides more than 50% of the member’s support and claims the member as a dependent for income tax purposes.

**Income Criteria**

➤ **Employment Income Documentation**

The plan eligibility technicians receive documentation for current employment income and payments received from other sources. Documentation of employment income can be a single pay stub reporting a year-to-date summary or three months’ pay stubs without a year-to-date *summary*; a letter, on official letterhead, from the applicant’s employer; or an employer’s payment ledger.

➤ **Cash From Other Sources Documentation**

Cash from other sources is gross cash received from sources other than employment. The following guidelines are used to evaluate whether cash from 16 types of sources is included as part of the applicant’s income:

- 1. Unemployment compensation is used if the applicant provides proof of unemployment payments such as the letter explaining benefits.
- 2. Old Age Pension (OAP) Benefits are included.
- 3. Supplemental Security Income (SSI) benefits are included except for SSI benefits received for minors.
- 4. Aid to the Needy and Disabled Program (AND) provides financial assistance for disabled people, ages 18 through 59. AND clients may or may not be Medicaid eligible. If AND applicants are Medicaid eligible, eligibility technicians do not include AND payments as cash from other sources. If AND applicants are not Medicaid eligible, technicians include AND assistance payments as cash from other sources.
- 5. Cash child support and foster care payments are not included.
- 6. Food stamps and payments through the Nutrition Program for Women, Infants, and Children (WIC) are not included.
- 7. Payments from retirement plans and pensions are included. Examples include PERA (state retirement plan), tax sheltered annuity payments, deferred compensation, Individual Retirement Account (IRA) withdrawals, 401k plans, and Social Security Benefits. Social Security Benefit payments to children are not included when calculating cash from other sources.
- 8. Commissions, bonuses, and tips are included.
- 9. Court-ordered alimony received by the family making application for the child is included. Alimony paid by a family is calculated as an income disallow if these payments were included on the prior year’s tax return.
- 10. Court-ordered child support payments are treated as income disallows when certain criteria are met. The payments must be documented with the last three months’ canceled checks or receipts. A court order showing that the applicant has been ordered to pay child support should also be presented.
- 11. Income from rental properties is included net of expenses.
- 12. Stipends (cash received by students that is not specifically designated for tuition and books) is included.

- 13. College loans are not included.
  - 14. College grants and scholarships are not included as cash from other sources unless the proceeds exceed the costs of tuition and books.
  - 15. Amounts drawn from trust accounts as cash from other sources.
  - 16. Interest earnings and capital gains from savings accounts, stocks, bonds, and similar securities transactions are included when calculating cash from other sources.
- Intangible income is the value of goods and services received as a substitute for monetary payments. These goods and services are usually room (shelter) and board (food) and do count toward the income calculation.

To calculate intangible income, technicians either ask the family the actual value of room and board **OR** use the Annual Room Value Table and the Annual Board Value Table to determine the annual values of room and board if the actual value is unknown.

**Room Value**

The room value table shows the annual values of separate units and rooms in metropolitan and non-metropolitan areas. To use the table, technicians determine if the family has a separate unit or is sharing a home and has its own rooms. Separate units have a separate bath, kitchen, and bedroom(s). If the applicant family has a separate unit, technicians determine the type of unit and if the unit is in a metropolitan or non-metropolitan area and use that amount when calculating intangible income.

If the applicant family is sharing a home, technicians determine the number of rooms the family has for personal use and if the shared home is in a metropolitan or non-metropolitan area.

TABLE 3:  
ANNUAL ROOM VALUE TABLE

Separate Units Type of Unit	Efficiency	1 Bedroom	2 Bedrooms	3 Bedrooms	4 Bedrooms	
Metropolitan Areas'	\$4,175	\$5,131	\$6,840	\$9,495	\$1 1,205	
Non-Metropolitan Areas'	\$3,710	\$4,163	\$5,005	\$6,250	\$8,199	
Number of Rooms	1	2	3	4	5	6
Metropolitan Areas'	\$1,392	\$1,710	\$2,280	\$3,165	\$3,735	\$5,602
Non-Metropolitan Areas <sup>2</sup>	\$1,237	\$1,388	\$1,668	\$2,083	\$2,732	\$2,869

Board Value

The board value table below shows the annual value of food.

TABLE 4:  
ANNUAL BOARD VALUE TABLE

Family Size	1	2	3	4	5	6	7	8
	\$1.440	\$2.640	\$3.780	\$4.800	\$5.799	\$6.840	\$7.560	\$8.640
For families larger than eight, add \$1,080 per year or \$90 pr month per family member								

- Payments not counted as income include:
1. Grants to clients from non-profit, tax exempt, charitable foundations specifically contributed for client enrollment fees or copayments.
  2. Assistance provided by non-profit organizations, if the assistance is need-based (i.e., the cost of meals at a soup kitchen).
  3. Medical care provided for free or if a third party made the payments.
  4. Payments by credit life or credit disability insurance.
  5. Proceeds of a loan.
  6. Disaster relief assistance.
  7. Tax refunds.
  8. IRAs and pensions which are not available without penalty.

Expense Criteria

Eligibility technicians ~~try~~ to obtain at least one month of documentation to verify all monthly expenses listed below. However, if some of the documentation is not available, technicians can rely on the applicant's verbal or written responses. Documentation may include actual receipts, credit card statements, credit checks, and records of checking and savings account activity.

Expense	Monthly Amount
Home Rent Expense	_____
Home Mortgage	_____
Child Support	_____
Electricity, gas	\$ _____
Water, Sewer, Trash	\$ _____
Telephone	\$ _____
Auto Loan	\$ _____
Auto Insurance	_____
Auto Maintenance and Gas	\$ _____
Child and Elder Care Expense	\$ _____
Entertainment	\$ _____
Groceries (food and toiletries) – DO NOT include the value of Food Stamps or WIC	_____
Diapers and Baby Formula	_____
Credit Cards	\$ _____
Loans	_____
Physician Expenses	\$ _____
Dental Expenses	\$ _____
Pharmacy Expense	_____
Eye Exam and Lenses Expense	\$ _____
Other Expenses (list)	\$ _____
_____	_____
_____	_____

These monthly expenses are totaled and multiplied by twelve to derive a family’s annual income using this method.

**Income Tax Return Criteria**

CCHP eligibility technicians use the most recently filed income tax return as an indication of the family’s probable future income. This criterion is applied most often when the family income is derived from seasonal work and the family indicates an “income exception.”

**Attachment 4:**  
**Resource Verification Criteria**

The Child Health Plan Plus will continue to use the Colorado Child Health Plan’s resource verification procedures described below.

**Resource Criteria**

- **Calculating Vehicle Equity**  
To calculate the amount of vehicle equity, the family reports the total value of all vehicles owned by members of the family unit. The family then reports the total amount owed on all vehicles. The plan protects a total of \$4,500 net asset value for all vehicles owned.
  
- 9 **Calculating Business Equity**  
If a family member owns a business, the eligibility technician will calculate the business equity by subtracting the amount owed on the business from the reported market value of the business. The plan protects a total of \$50,000 for all businesses owned.
  
- 9 **Calculating Liquid Assets**  
Liquid assets are assets that can be converted to cash immediately. Examples of liquid assets are: saving accounts, trust accounts (if funds are available immediately), the cash value of life insurance, short term Certificate of Deposits (CD’s), and partnership earnings kept in reserve. Retirement accounts and tax sheltered annuities are liquid assets, *if* the applicant can draw funds out of the account without a penalty.
  
- **Calculating Family Size Deductions**  
The CCHP protects \$2,500 in asset equity per family member.

Total resources recorded for the family cannot be a negative number.

**Spend Down Criteria**

- 9 **Income Disallows**  
CCHP eligibility technicians will directly disallow all documented child support payments; medical bills incurred by the family which are due and payable over the next twelve months; and all daycare expenses. Medical expenses include medical services received at hospitals, clinics, private physicians’ offices, and pharmacists. Disallowed daycare expenses do not include.

**Attachment 5:  
Residency Criteria**

**Residency Criteria**

➤ **U.S. Citizen**

A U.S. citizen is a person who meets *one* of the following criteria:

1. Born in the United States, Puerto Rico, Guam, Virgin Islands of the United States, American Samoa, and Swain's Island. A birth certificate will prove that a person was born a U.S. citizen, **OR**
2. Received citizenship through the naturalization process. A certificate of citizenship will prove that a person is a U.S. citizen.

➤ **Documented Immigrants**

Documented immigrants are persons who reside in the United States and possess *one* of the following Immigration and Naturalization Service (INS) documents:

- 1-551 resident alien card;
- I-688B or I-766 employment authorization card;
- I-94 arrival-departure record;
- Immigrants granted "voluntary departure" or "indefinite stay of deportation."

Effective July 1, 1997, a receipt of application for a Social Security number and proof of entry must be received at time of the application.

➤ **Colorado Resident**

**A Colorado resident is a person who currently lives in Colorado and intends to remain in the state.**

➤ **Migrant Workers**

Migrant workers and all dependent family members must meet *all* of the following criteria to comply with CCHP residency requirements:

1. The applicant family does not live permanently in Colorado but does maintain a temporary home in Colorado for employment reasons.
2. The applicant family meets the U.S. citizen or documented immigrant criteria.
3. At least one member of the applicant family must be employed in Colorado.

**Eligibility is extended to dependent family members when the residency requirements are met.**

➤ **Applicants Not Eligible for the CCHP**

- 1. Undocumented immigrants.
- 2. College students from outside Colorado or the United States who are in Colorado for the purpose of education.
- 3. Visitors from other states or countries temporarily visiting Colorado who have primary residences outside of Colorado.

**Attachment 6:**  
**Child Health Plan Plus Family Premium Cost Sharing**

**Premium Cost-Sharing for Families through 149% FPL**

%FPL						Premium contribution for children who enroll by 12/31/97	Premium contribution for children who enroll between 1/1/98 and 6/30/98
	2	3	4	5	6		
Up to 40%	≤\$4,244	≤\$5,332	≤\$6,420	≤\$7,508	≤\$8,596	waived	waived
41-62%	\$4,350-\$6,578	\$5,465-\$8,265	\$6,581-\$7,696	\$7,696-\$11,637	\$8,811-\$13,324	id	id
63-81%	\$6,684-\$8,594	\$8,398-\$10,797	\$10,112-\$13,001	\$11,825-\$15,204	\$13,539-\$19,407	\$2.50/family/month	\$5/family/month
82-100%	\$8,700-\$10,610	\$10,931-\$13,330	\$13,161-\$16,050	\$15,391-\$18,770	\$17,622-\$21,490	\$5/family/month	\$10/family/month
101-149%	\$10,716-\$15,809	\$13,463-\$19,862	\$16,211-\$23,915	\$18,985-\$27,967	\$21,705-\$32,020	\$7.50/family/month	\$15/family/month

**Premium Cost-Sharing for Families from 150% through 185% FPL**

%FPL	Family Size				
	2	3	4	5	6
150-185%	\$15,915-\$19,629	\$19,995-\$24,661	\$24,075-\$29,693	\$28,155-\$34,725	\$32,235-\$39,757

**Premium Contributions per family per month**

150-185% FPL	Number of Children*				
	1	2	3	4	5
Enrolled in CHP+ by 12/30/98	\$10	\$12.50	\$15	\$17.50	\$20
Enrolled in CHP+ 1/1/98-6/30/98	\$20	\$25	\$30	\$35	\$40

**Attachment 7:**  
**Child Health Plan Plus Benefits and Co-Payments for**  
**SERVICES DELIVERED THROUGH HMOs**

	DESCRIPTION OF BENEFIT	COPAY	
		<150% FPL	>150% FPL
1. ANNUAL DEDUCTIBLE Individual Family	None.	None. None.	None. None.
2. COINSURANCE OR COPAY Individual Family	Co-payment depends on the service.		
3. INPATIENT	Covered. Inpatient services includes all physician, surgical and other services delivered during a hospital stay. Inpatient services covered in full with no co-pays.	\$0	\$0
4. OUTPATIENT SERVICES	Covered. Outpatient services include outpatient surgery covered in full with no co-pays.	\$0	\$0
5. PHYSICIAN SERVICES	Physician services include medical office visits with a physician, mid-level practitioner or specialist. Preventive care (well-child care, well-baby care, and immunizations) covered in full with no co-pay.	\$2	\$5
		\$0	\$0
6. SURGICAL SERVICES	Covered. Outpatient surgical services. Inpatient surgical services.	\$0 \$0	\$0 \$0
7. CLINIC SERVICES	Clinic services and other ambulatory health care services covered. Preventive care (well-child care, well-baby care, and immunizations) covered in full with no co-pay.	\$2 \$0	\$5  E5 – brand
8. PRESCRIPTION DRUGS	Covered.	\$1	
9. LABORATORY & X-RAY SERVICES	Covered.	\$0	

	DESCRIPTION OF BENEFIT	COPAY	
		<150% FPL	>150% FPL
<b>10. MATERNITY CARE</b>			
Prenatal	Covered.	\$0	\$0
Delivery & inpatient well baby care	Covered.	\$0	\$0
<b>11. INPATIENT MENTAL HEALTH SERVICES</b>	Covered for 45 days of inpatient mental health services with an exception clause to review cases for children needing longer hospital stays. Inpatient treatment for alcohol and substance abuse treatment not covered.	\$0	\$0
<b>12. OUTPATIENT MENTAL HEALTH SERVICES</b>	Covered. 20 visit limit.	\$2	\$5
<b>13. DURABLE MEDICAL EQUIPMENT</b>	Maximum \$2,000/year paid by plan. Coverage for lesser of purchase price or rental price for medically necessary durable medical equipment, including home administered oxygen.	\$0	\$0
<b>14. ABORTION</b>	Only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.	\$0	\$0
<b>15. DENTAL SERVICES</b>	Coverage for emergency assessments and preventive dental care.	\$2	\$5
<b>16. PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY</b>	30 visits per diagnosis per year.	\$2	\$5
<b>17. HOSPICE CARE</b>	Covered.	\$0	\$0
<b>18. MEDICAL TRANSPORTATION</b>	Hospital and emergency room transport covered.	\$15 Waived with admission into ER or hospital.	\$15 Waived with admission into ER or hospital.
<b>19. NEUROBIOLOGICALY -BASED MENTAL ILLNESS</b>	Covered. State law requires the following to be treated as any other illness or condition: schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive compulsive disorder, and panic disorder. Applies to all group health benefit plans.	\$2	\$5

	DESCRIPTION OF BENEFIT		
		<150% FPL	>150% FPL
20. ORGAN TRANSPLANTS	Covered transplants include liver, heart, headlung, cornea, kidney, and bone marrow for aplastic anemia, leukemia, immunodeficiencydisease, neuroblastoma, lymphoma, high risk state II and state III breast cancer, and Wiskott Aldrich Syndrome only. Peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants. Transplants will be covered only if they are medically necessary and the facility meets clinical standards for the procedure.	\$0	\$0
21. VISION SERVICES	Vision screenings are covered as age appropriate preventive care. Referral required for refraction services. \$50 annual benefit for eyeglasses. Vision therapy covered.	\$2	\$5
22. AUDIOLOGICAL SERVICES	State mandate that hospitals cover newborn hearing screenings. Coverage needs to include assessment as well as diagnosis. Hearing aides covered for congenital and traumatic injury. Maximum \$800/year paid by plan.	\$0	\$0
23. INTRACTABLE PAIN	Included as a benefit with the medical office visit co-payment.	\$2	\$5
24. AUTISM COVERAGE	Included as a benefit with the medical office visit co-payment. (9/18/97)	\$2	\$5
25. SKILLED NURSING FACILITY CARE	Covered, Care must follow a hospital confinement and the skilled nursing facility confinement must be the result of an injury or sickness that was the cause of the hospital confinement. Benefits will not be paid for custodial care or maintenance care or when maximum medical improvement is achieved and no further significant measurable improvement can be anticipated.	\$0	\$0
26. DIAGNOSIS, ASSESSMENT, AND REFERRAL FOR ALCOHOL AND SUBSTANCE ABUSE TREATMENT	Covered services as defined by Guidelines for Adolescent Preventive Services (GAPS).	\$0	\$0

Child Health Plan Plus Benefits and Co-Payments for  
**SERVICES DELIVERED THROUGH CHP+ PROVIDER NETWORK**

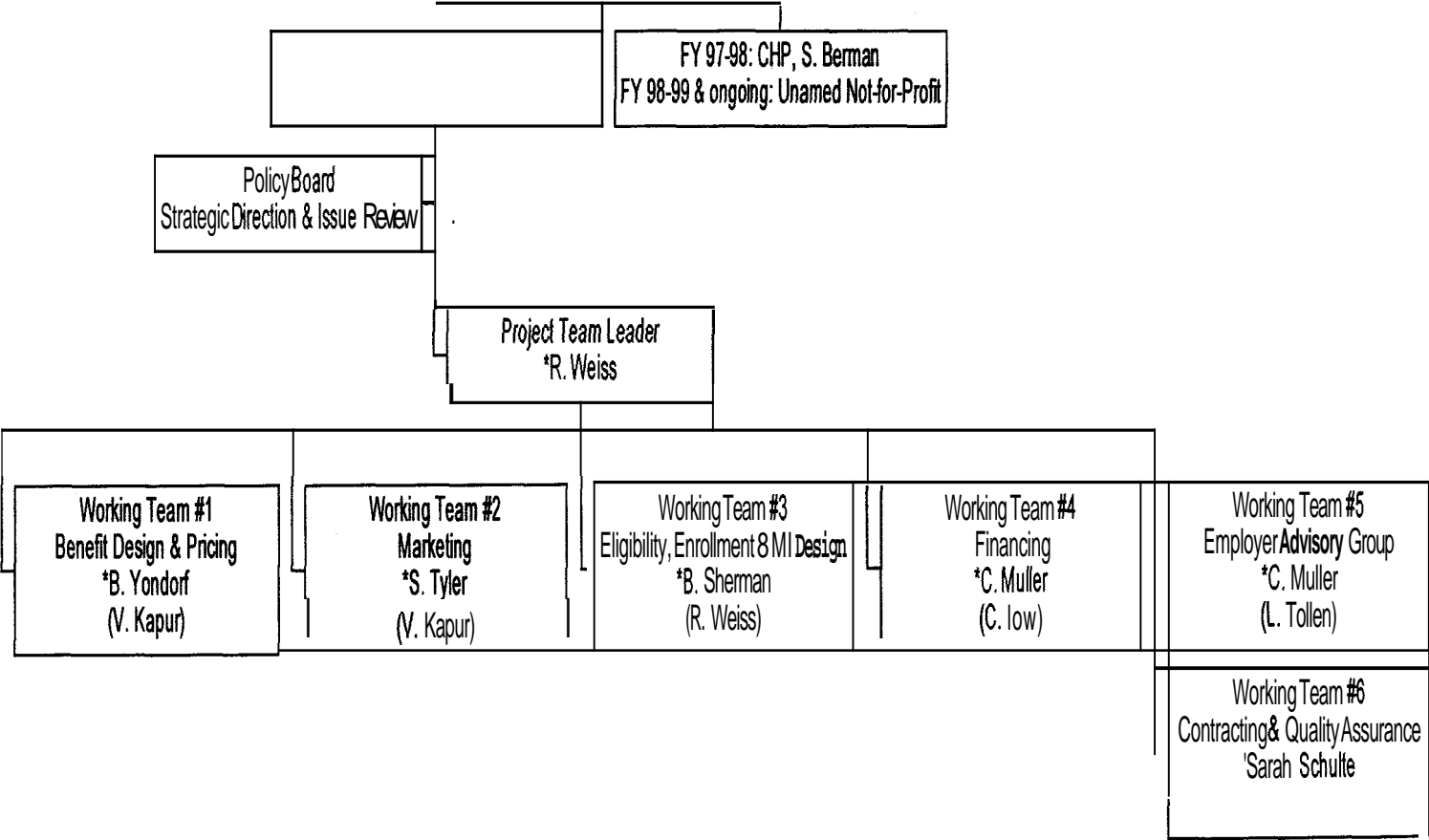
	DESCRIPTION OF BENEFIT	COPAY
1. ANNUAL DEDUCTIBLE Individual Family	None.	None. None.
2. COINSURANCE OR COPAY Individual Family	Co-payment depends on the service.	
3. INPATIENT	Covered. Inpatient services includes all physician, surgical and other services delivered during a hospital stay. Inpatient services covered in full with no co-pays.	\$0
4. OUTPATIENT SERVICES	Covered. Outpatient services include outpatient surgery covered in full with no co-pays.	\$0
5. PHYSICIAN SERVICES	Physician services include medical office visits with a physician, mid-level practitioner or specialist. Preventive care (well-child care, well-baby care, and immunizations) covered in full with no co-pay.	\$2 \$0
6. SURGICAL SERVICES	Covered. Outpatient surgical services. Inpatient surgical services.	\$0 \$0
7. CLINIC SERVICES	Clinic services and other ambulatory health care services covered. Preventive care (well-child care, well-baby care, and immunizations) covered in full with no co-pay.	\$2 \$0
8. PRESCRIPTION DRUGS	Covered.	\$2
9. LABORATORY & X-RAY SERVICES	Covered.	\$0

	DESCRIPTION OF BENEFIT	COPAY
9. MATERNITY CARE Prenatal	Covered.	\$0
Delivery & inpatient well baby care	Covered.	\$0
10. INPATIENT MENTAL HEALTH SERVICES	Covered for 45 days of inpatient mental health services with an exception clause to review cases for children needing longer hospital stays. Inpatient treatment for alcohol and substance abuse treatment not covered.	\$0
11. OUTPATIENT MENTAL HEALTH SERVICES	Covered. 20 visit limit.	\$2
12. DURABLE MEDICAL EQUIPMENT	Maximum \$2,000/year paid by plan. Coverage for lesser of purchase price or rental price for medically necessary durable medical equipment, including home administered oxygen.	\$0
13. ABORTION	Only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.	\$0
14. PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY	30 visits per diagnosis per year.	\$2
15. NEUROBIOLOGICALY -BASED MENTAL ILLNESS	Covered. State law requires the following to be treated as any other illness or condition: schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive compulsive disorder, and panic disorder. Applies to all group health benefit plans.	\$2
16. VISION SERVICES	Vision screenings are covered as age appropriate preventive care. Referral required for refraction services. \$50 annual benefit for eyeglasses. Vision therapy covered.	\$2
17. AUDIOLOGICAL SERVICES	State <b>mandate</b> that hospitals cover newborn hearing screenings. Coverage needs to include assessment <b>as well as</b> diagnosis. Hearing aides covered for congenital and traumatic injury. Maximum \$800/year paid by plan.	\$0
18. INTRACTABLE PAIN	Included as a benefit with the medical office visit co-payment.	\$2

	DESCRIPTION OF BENEFIT	COPAY
19. DIAGNOSIS, ASSESSMENT, AND REFERRAL FOR ALCOHOL AND SUBSTANCE ABUSE TREATMENT	Covered services as defined by Guidelines for Adolescent Preventive Services (GAPS).	\$0

# Attachment 8:

## Children's Basic Health Plan: Implementation Structure



\*Team Lead

Attachmen 9:  
Children’s Basic Health Plan Policy Board and Working Teams

CBHP POLICY BOARD

**Function:** The mission of the Policy Board is to provide strategic direction for the CBHP and to review major issues in its design and implementation. The Policy Board will seek to work by consensus to the extend possible.

**Board Members**

Lua Blankenship  
President  
The Children’s Hospital

Thom Williams  
Vice President  
TIAA-CREF

Patricia Cahill  
President and CEO  
Catholic Health Initiatives

Dr. Albert C. Yates  
President  
Colorado State University

C. David Kikumoto  
President and CEO  
Blue Cross and Blue Shield

Paul Melinkovich, M.D.  
Denver Health Medical Center

*Ex Officio Members*

Barbara O’Brien  
President  
Colorado Children’s Campaign

Steve Berman, **M.D.**  
Director of Health Policy  
University of Colorado Health Sciences  
Center

Kate Paul  
CEO  
Kaiser Permanente of Colorado

Bernie Buescher  
Executive Director  
Colorado Department of Health Care Policy  
and Financing

David Price, M.D.  
Past President  
Colorado Academy of Family Physicians

Jack Ehnes  
Commissioner of Insurance  
Colorado Department of Regulatory Agencies

Col. Michael Quinlan  
Regional Senior Vice President  
USAA – Mountain States Region

State Senator Sally Hopper  
Colorado State Senate

Marguerite Salazar  
President and CEO  
Valley-Wide Health Services

State Representative David Owen  
Colorado House of Representatives

David S. Shanks  
Bright Beginnings

Michael Rothman  
Director  
Office of Public & Private Initiatives  
Colorado Department of Health Care Policy  
& Financing

George Sparks  
General Manager  
Hewlett-Packard Company  
Solutions Services Division

Patti Shwayder  
Executive Director  
Colorado Department of Public Health &  
Environment

Thomas Stokes  
President  
Gates Capital Management  
Mel Takaki, DDS  
Takaki Dental Center

Michael J. Weber  
Executive Director  
Rocky Mountain HMO

Working Team #1: Benefits Design and Pricing

**Function:** To design and price the benefit package and to design the premium subsidy structure.

Members

Johnathan Asher  
Executive Director  
Legal Aid Society

Jennifer Laman  
Colorado Community Health Network

Buffy Boesen  
All Families Deserve A Chance Coalition

Virgilio Licona, M.D.  
Medical Director  
Colorado Access

Rick Bowles  
Medicaid Program Manager  
United Health Care of Colorado

Michelle Laisure  
Manager  
Colorado Medically Indigent Program  
Colorado Department of Health Care Policy  
& Financing

Diane Covington  
Director, Oral Health  
Colorado Department of Public Health and  
Environment

Charline Mann  
Secretary, Board of Directors  
Colorado Alliance for the Mentally Ill

Joan Haid  
EPSDT Team Leader  
Boulder County Health Department

~~Barry~~ Martin, M.D  
Director of Clinical Services  
Metropolitan Denver Provider Network

Natalie Herlends  
Senior Counsel  
Community Health Plan of the Rockies

Myrle Myers  
Director of State Government Affairs  
Johnson & Johnson

David Herr. M.D.  
Associate Medical Director  
Rocky Mountain HMO

Shirley Ney  
HCFA Region VIII Office

Kathy Nichols  
Services Manager  
Planned Parenthood of the Rocky Mountains

Jim Johnston  
Foundation Health and  
QualMed Health Plan

Lisa Olson  
Service Coordinator  
Colorado Child Health Plan

M. Douglas Jones, M.D.  
Pediatrician-in-Chief (TCH)  
Professor and Chair  
Department of Pediatrics  
The Children’s Hospital

Michele Patarino  
Blue Cross and Blue Shield

Chris Pon  
Executive Director  
Colorado Uninsurable Health Insurance  
Program

Courtney Thomas  
Director  
Child Health Services  
Colorado Department of Public Health &  
Environment

Peggy Sandbak  
President  
Sandbak & Company

Laura Tollen  
Office of Public & Private Initiatives  
Colorado Department of Health Care Policy  
& Financing

Don Schiff, M.D.  
Professor of Pediatrics  
The Children’s Hospital

Cathy Waters  
Handicapped Children’s Program  
Department of Public Health & Environment

Linda Therrien  
Director  
Community Health Programs

Carole Workman-Allen  
Office of Medical Assistance  
Division of Managed Care Contracting  
Colorado Department of Health Care Policy  
& Financing

Barbara Yondorf  
Director of Policy & Research  
Division of Insurance  
Colorado Department of Regulatory Agencies

Working Team #2: Marketing

**Function:** To develop and implement a marketing plan to expand the Child Health Plan during SFY 1997-1998 and the transition to the Children’s Basic Health Plan in SFY 98-99.

Members

Cheryl Barnes Office of Medical Assistance Eligibility & Enrollment Section Colorado Department of Health Care Policy & Financing	Vatsala Kapur Office of Public & Private Initiatives Colorado Department of Health Care Policy & Financing
Steve Blatt Synapse, Inc. Strategic Marketing	Jennifer Laman Colorado Community Health Network
Karen Connell Colorado Department of Education	Rosemary Marshall Director of Public Relations Colorado Department of Labor and Employment
Jane Cotler Child Health Services Colorado Department of Public Health and Environment	Sally Maxey Family Voices
Diane DiGiacomo Peck Communications Officer Piton Foundation	Shirley Ney/Dee Raisl HCFA Region VIII Office
Edie Dulacki Johnston & Wells	Betty Pepin Administrator Director Commerce City Community Health Services
Beth Elland Community Partnerships St. Anthony Health Services	Gary Redabaugh Blue Cross and Blue Shield
Jane Gerberding Larimer County Department of Public Health	John Romero Campbell LA RASA
Tracy D’Angelo The Alliance	Ronnie Rosenbaum Director Shared Beginnings Centura/St. Anthony’s Hospital

Paula Hudson  
Health Care Program for Children with  
Special Needs  
Colorado Department of Public Health &  
Environment

Rhonda Johnston  
Executive Director  
School-based Wellness Centers

Neil Kesselman, M.D.  
President  
Colorado Chapter of the American Academy  
of Pediatrics

Karen Shields  
Connections Coordinator  
Kaiser Permanente

Troy Sinar  
Marketing Manager  
SALUD Family Health Centers

Lucy Trujillo  
Colorado Foundation for Families and  
Children

Susan Tyler  
Outreach Coordinator  
Child Health Plan

**Working Team #3: Eligibility, Enrollment and  
Management Information System Design**

**Function:** To design the eligibility, enrollment, and management information systems for the Children’s Basic Health Plan.

**Members**

Dixie Anderson Colorado Department of Human Services	Annette Kowal Colorado Community Health Network
Colleen Bryan Project Manager Colorado Benefit Management System Department of Health Care Policy and Financing	Kate Lutz EPSDT Manager Office of Medical Assistance Colorado Department of Health Care Policy & Financing
Chrystal Burrell Office of Medical Assistance Colorado Department of Health Care Policy & Financing Ned Calonge, M.D. Kaiser Permanente	Jessie Gray Denver Health and Hospitals
Charlotte Corrales Ignacio Indian Health Clinic	Jennifer Mauldin Handicapped Children’s Program Colorado Department of Public Health & Environment
Diane Dunn Office of Medical Assistance Colorado Department of Health Care Policy & Financing	Patsy McAteer Handicapped Children’s Program Colorado Department of Public Health & Environment
Norma Edelman EPSDT Administrative Service Trainer Colorado Department of Public Health & Environment	Brian Montague Colorado Child Health Plan
Connie Eldridge Blue Cross and Blue Shield	Bonnie Sherman Executive Director Colorado Child Health Plan
	Ann Taylor Executive Director Doctors Care

Sally Harmon  
Office of Medical Assistance  
Eligibility & Enrollment Section  
Colorado Department of Health Care Policy  
& Financing

Barbara Hinson  
Executive Director  
Children’s Clinic

Ha Hoang  
Manager of Eligibility and Enrollment  
Colorado Child Health Plan

Beth Neva  
Office of Information Technology  
Colorado Department of Health Care Policy  
& Financing

Cathy Van Doren  
Director  
The Alliance

Kim Walkenhorst  
EPSDT Case Manager  
Larimer County Health Dept.

Rebecca Weiss  
Health Policy Analyst  
Office of Public & Private Initiatives  
Colorado Department of Health Care Policy  
& Financing

Danielle Urban  
Market Development Planner  
Kaiser Permanente

**Working Team #4: Financing**

**Function:** To ensure the Children’s Basic Health Plan complies with state and federal financing regulations, to secure the proper flow of funds, and to conduct the analyses necessary to ensure sound financial management.

**Members**

Cindy Baouchi  
Budget Analyst  
Colorado Department of Health Care Policy  
& Financing

Charla Low  
Director of Finance and Operations  
Child Health Plan

Ray Coffey  
Budget Analyst  
Colorado Department of Health Care Policy  
& Financing

Peggy Hill  
Research Associate  
Prevention Research Center for Family and  
Child Health

Lisa Fox  
Manager, Colorado Indigent Care Program  
Colorado Department of Health Care Policy  
& Financing

Melanie Melcher  
Budget Analyst  
Office of State Planning & Budgeting

Joe Keebaugh  
Office of Accounting & Purchasing  
Colorado Department of Health Care Policy  
& Financing

Cammie Muller  
Statistical Analyst  
Office of Public and Private Initiatives  
Colorado Department of Health Care Policy  
& Financing

Michelle Laisure  
Colorado Indigent Care Program  
Colorado Department of Health Care Policy  
& Financing

Pam McManus  
Chief Financial Officer  
Community Health Center, Inc.

Jennifer Laman  
Colorado Community Health Network

**Working Team #5: Employer Advisory Group**

**Function:** To design the employer buy-in components of the Children’s Basic Health Plan.

**Members**

Melinda Anderson  
Business Financial Manager  
Mile Hi Child Care Centers

Annmarie Castro  
Health Plan Manager  
US West, Inc.

Ron Chatterton  
Human Resources  
Eastman Kodak Company

Annemarie Chenoweth  
President  
Neoplan

Gayle Collins  
Cleo Wallace Center

Jay Derks  
Mile Hi Child Care Centers

Jennifer Laman  
Colorado Community Health Network

Liz Leif  
Leif Associates, Inc.

Bill Lindsay  
President  
Benefit Management and Design

Cammie Muller  
Statistical Analyst  
Office of Public and Private Initiatives  
Colorado Department of Health Care Policy  
& Financing

Jim Palmer, Vice President  
Colorado Springs Chamber of Commerce

Joy Pickar  
Assistant Director, Government Relations  
State Farm Insurance Companies

Gerald Renteria  
Manager, Human Resources  
Graphic Packaging Corporation

Carla Rowland  
Colorado Child Health Plan

Walt Speckman  
Executive Director  
Weld County Human Services Department

Laura Tollen  
Health Policy Analyst  
Office of Public and Private Initiatives  
Colorado Department of Health Care Policy  
& Financing

Dorothy Marshall  
David A. Marshall Associates

Peggy Morrison  
Chief Financial Officer  
Clinica Campesina  
Lafayette Clinic

John Moyski  
President  
Ponderosa Industries, Inc.

Cathy Van Doren  
Director of Managed Care  
The Alliance

Danielle Urban  
Market Development Planner  
Kaiser Permanente

**Ad-Hoc Members**

Loretta Archuleta  
Executive Director  
Rehabilitation & Performance Medicine  
Specialists

Judy Glazner  
University of Colorado Health Sciences  
Center

Jean Barker  
Director, Planning/Management Engineering  
Kaiser Permanente

Mike McArdle, Director  
Colorado Assn. Of Commerce and Industry

Kathy Bartilotta  
Principal  
KB Associates

*Gary* Redabaugh  
Senior Group Consultant  
Blue Cross/Blue Shield of Colorado

Pat Butler  
Consultant

Richard Rush  
Vice President, Actuarial Services  
FHP Wealth Care

Ellen Day  
Gauthier Construction Company

Actuarial Report

Child Health Plan Plus

October 1997

Actuarial Report  
Child Health Plan Plus  
October 1997

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**Background**

This actuarial report was developed at the request of the Colorado Department of Health Care Policy and Financing by *Leif Associates, Inc.*, an independent actuarial consulting firm. The purpose of the report is to supplement the State of Colorado's application for Federal funds under Title XXI of the Social Security Act for the Child Health Plan Plus.

Title XXI, Section 2103, specifies that the scope of health insurance coverage under this program must consist of either benchmark coverage, benchmark-equivalent coverage, existing comprehensive state-based coverage, or Secretary-approved coverage. Certain actuarial values must be set forth in an actuarial opinion in an actuarial report to accompany the State's application. Those actuarial values include the following:

- The actuarial value of the coverage provided by the benchmark benefit packages;
- The actuarial value of the coverage offered under the State child health plan;
- The actuarial value of the coverage of any categories of additional services under benchmark benefit packages; and,
- The actuarial value of any categories of additional services under coverage offered by the State child health plan.

This actuarial report includes the actuarial values listed above, along with supporting documentation and other information.

**Benchmark Benefit Packages**

The benchmark benefit packages identified in Title XXI, Section 2103, are as follows:

- FEHBP-equivalent children's health insurance coverage. This *is* described as the standard Blue Cross/Blue Shield preferred provider option service benefit plan, described in and offered under section 8903(1) of title 5, United States Code.

The Blue Cross/Blue Shield preferred provider option service benefit plan is composed of an in-network benefit and an out-of-network benefit package. As stated in FEHBP documentation, the non-PPO benefits are the standard benefits of the plan. PPO benefits apply only when the covered person uses a PPO provider. Therefore, the non-PPO benefits of the FEHBP plan were used in this study to determine the actuarial value of FEHBP coverage.

- State employee coverage. This is described as a health benefits coverage plan that is offered and generally available to State employees in the State involved.

The State of Colorado currently offers five HMO and three self-funded health benefit plans for its employees to choose from. The plan that currently has the largest enrollment is known as the Exclusive Path. This plan covers approximately 15,000 State employees and their dependents, out of a total of approximately 28,000 State employees that are covered under the State's employee health benefit plans. The Exclusive Path uses a large network of health care providers, and coverage is provided only when care is secured from those providers. It has the typical plan design features of an

HMO plan. For purposes of this study, the Exclusive Path was chosen as the benchmark state employee benefit coverage

- **Coverage offered through an HMO.** This is described as the health insurance coverage plan that:
  - (A) is offered by a health maintenance organization (as defined in section **2791** (b)(3) of the Public Health Service Act), and
  - (B) has the largest insured commercial, non-Medicaid enrollment of covered lives of such coverage plans offered by such a health maintenance organization in the State involved.

In order to determine the HMO benchmark coverage for Colorado, an informal survey of the largest HMOs in the state was conducted by the Colorado Department of Health Care Policy and Financing. Based on this informal survey, it was determined that the HMO plan that has the largest insured commercial, non-Medicaid enrollment of covered lives in Colorado is the Kaiser Foundation Health Plan of Colorado Plan **710**, with pharmacy, durable medical equipment, and optical riders. This plan was used as the benchmark HMO coverage for purposes of this study.

A plan design grid, which shows the details of the benefits of these three benchmark plans, is attached to this report and labeled as Exhibit I.

***Child Health Plan Plus Benefit Packages***

The benefit structure for the Child Health Plan Plus will vary depending on whether HMO plans are available. The fee-for-service program will be available in areas where no HMO coverage is available.

The proposed HMO Child Health Plan Plus includes two separate benchmark-equivalent benefit packages. One is for children in families between 100% and **150%** of the Federal poverty level. The other is for children in families between **150%** and **185%** of the Federal poverty level. The plans each provide coverage for the same health care services. The only difference between the two plans is the level of cost sharing. Copayments, when required, will be higher for participants with family incomes between **150%** and **185%** of the Federal poverty level than for participants with family incomes between 100% and **150%** of the Federal poverty level.

A plan design grid, which shows the details of all three Child Health Plan Plus benefit packages, is attached to this report and labeled as Exhibit II. The coverage includes benefits for items and services within each of the categories of basic services described in Section 2 **103**.

***Methodology for Determining Actuarial Equivalency***

In order to determine the actuarial equivalency of the proposed Child Health Plan Plus benefit packages to the benchmark plans, the following methodology was used.

- **Identification of a standardized set of utilization and price factors.**

The standardized set of utilization and price factors used to determine the actuarial equivalency of the Child Health Plan Plus to the benchmark plans is set forth in Exhibit III of this report. These standardized utilization and price factors have the following characteristics:

- 1) The factors were based on a compilation of data from a number of unpublished sources;
- 2) The factors were adjusted to reflect weighted statewide Colorado health care utilization and costs, rather than those for a specific geographic location within Colorado;

- 3) The factors represent the unique health care utilization and cost patterns for children, rather than adults or the combination of children and adults;
- 4) The factors were developed for children at various ages and weighted using the standardized population of children described below to arrive at combined average factors for children under nineteen years of age;
- 5) The factors were projected to mid-year 1998, using typical utilization and cost trends;
- 6) The factors were based on typical insured coverage utilization and costs in a traditional fee-for-service environment with limited utilization management;
- 7) The development of the factors involved considerable actuarial judgement.

■ **Identification of a standardized population.**

The standardized population used to determine the actuarial equivalency of the Child Health Plan Plus to the benchmark plans is set forth in Exhibit IV of this report. This standardized population is the projected 1997 Colorado population by single age for children ages 0 through **18**, as determined by the U.S. Bureau of the Census, Population Projections Branch. This standardized population is believed to be representative of the distribution of privately insured children of the age of children who are expected to be covered under the State child health plan.

■ **Calculation of the actuarial value of the benchmark plans and the categories of additional services included in the benchmark plans.**

Based on the standardized set of utilization and cost factors and the standardized population described above, the aggregate actuarial value and the actuarial value of categories of additional services provided by the three benchmark benefit plans was determined. The actuarial values, stated in terms of average monthly claim costs, are set forth below.

	<i><b>FEHBP Coverage</b></i>	<i><b>State Employee Coverage</b></i>	<i><b>HMO Coverage</b></i>
Aggregate Actuarial Value	\$74.35	<b>\$ 81.81</b>	\$ 82.71
Additional Services Actuarial Value			
Prescription Drugs	\$ 4.21	\$ 4.53	\$ 6.11
Mental Health Services	\$ 6.39	\$ 6.50	\$ 6.54
Vision Services	\$ -0-	\$ 0.70	\$ 0.92
Hearing Services	\$ -0-	\$ 0.29	\$ 0.19

In calculating the actuarial values stated above, the same actuarial principles and standardized factors were used in comparing the value of different coverage and categories of services, without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used.

■ **Calculation of the actuarial value of the Colorado plans and the categories of additional services included in the Colorado plans.**

Based on the standardized set of utilization and cost factors and the standardized population described above, the aggregate actuarial value and the actuarial value of categories of additional services provided by the proposed Colorado plans was determined. The actuarial values, stated in terms of average monthly claim costs, are set forth below.

	<i>Fee-For-Service Plan</i>	<i>HMO Plans</i>	
		<i>Between 100% and 150% FPL</i>	<i>Between 150% and 185% FPL</i>
Aggregate Actuarial Value	\$ 87.91	\$98.43	\$96.69
Additional Services Actuarial Value			
Prescription Drugs	\$ 6.67	\$ 6.86	\$ 6.22
Mental Health Services	\$ 6.63	\$ 6.63	\$ 6.60
Vision Services	\$ 1.04	\$ 1.04	\$ 1.00
Hearing Services	\$ .65	\$ 0.65	\$ 0.65

In calculating the actuarial values stated above, the same actuarial principles and standardized factors were used in comparing the value of different coverage and categories of services, without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used.

The cost sharing reflected in the benefit structure for participants below 150% of Federal poverty level meets the requirements stated in Section 2103 (e) (3). The copayments for participants between 150% and 185% of Federal poverty level are minimal, and when combined with the proposed premium payments for the program, are not expected to result in cost sharing that exceeds 5% of family income. Therefore, it is expected that the actuarial values shown above will not be increased because of cost sharing limitations which might otherwise result in an increase in the actuarial value of the plans.

It is important to recognize that the actuarial values developed from the standardized utilization and cost factors in this report do not represent the actual expected costs of the Child Health Plan Plus. The program is expected to include significant utilization management and negotiated provider reimbursements through the implementation of HMO contracts. It is also expected that the age distribution of children enrolled in the plan will not mirror that of privately insured children, as reflected in the Colorado population projections. Assumptions regarding the cost impact of managed care approaches and the actual expected enrollment distribution are not included in this report.

▪ **Determination of actuarial equivalence of the Colorado plans to the benchmark plans.**

The proposed Child Health Plan Plus benefit packages have an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark benefit packages. The actuarial value of these benefit packages exceeds the actuarial value of all three benchmark benefit packages.

With respect to each of the categories of additional services described in Section 2103, the proposed Child Health Plan Plus benefit packages have an actuarial value that is equal to at least 75 percent of the actuarial value of the coverage of that category of services in the benchmark packages. The actuarial value of these additional services exceeds the actuarial value of the corresponding additional service in each of the three benefit plans. A summary table is shown below.

	<i>Benchmark Plans</i>			<i>Colorado Plans</i>		
	<i>FEHBP Coverage</i>	<i>State Employee Coverage</i>	<i>HMO Coverage</i>	<i>Fee-For- Service Plans</i>	<i>HMO 100% to 150% FPL</i>	<i>HMO 150% to 185% FPL</i>
Aggregate Actuarial Value	\$74.35	<b>\$81.81</b>	\$82.71	\$87.91	\$98.43	\$96.69
Additional Services Actuarial Value						
Prescription Drugs	\$ 4.21	\$ 4.53	\$ 6.11	\$ 6.67	\$ 6.86	\$ 6.22
Mental Health Services	\$ 6.39	<b>\$ 6.50</b>	\$ 6.54	\$ 6.63	\$ 6.63	\$ 6.60
Vision Services	\$ -0-	\$ 0.70	\$ 0.92	\$ 1.04	\$ 1.04	\$ 1.00
Hearing Services	\$ -0-	\$ 0.29	<b>\$ 0.19</b>	<b>\$ 0.65</b>	<b>\$ 0.65</b>	\$ .65

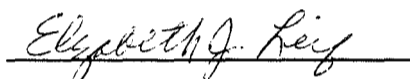
### ***Report Preparation***

Elizabeth J. Leif, Consulting Actuary and President of Leif Associates, Inc., a private actuarial consulting firm, prepared this actuarial report. **Ms.** Leif is a Fellow of the Society of Actuaries, a Fellow of the Conference of Consulting Actuaries, and a member of the American Academy of Actuaries.

### ***Actuarial Opinion***

I, Elizabeth J. Leif, a member of the American Academy of Actuaries, have performed the actuarial calculations described in this report and prepared the report and supporting documentation. It is my opinion that:

- The report has been prepared using generally accepted actuarial principles and methodologies;
- The report has been prepared in accordance with the principles and standards of the Actuarial Standards Board for such reports;
- A standardized set of utilization and price factors has been used;
- A standardized population that is representative of privately insured children of the age of children who are expected to be covered under the Child Health Plan Plus has been used;
- The same principles and factors have been applied in comparing the value of different coverage (or categories of services);
- Differences in coverage based on the method of delivery or means of cost control or utilization used have not been taken into account;
- The ability of the State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under the Child Health Plan Plus that results from the limitations on cost sharing under such coverage has been taken into account.



Elizabeth J. Leif, FSA  
Consulting Actuary  
Leif Associates, Inc.  
707 Seventeenth Street, Suite 2900  
Denver, CO 80202  
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October 10, 1997

Child Health Plan Plus  
Benchmark Benefit Packages

Benefit Category			1997 Colorado State Employee Coverage – Exclusive Path	HMO Plan – Kaiser Permanente Plan 710
	PPO	Non-PPO <sup>1</sup>		
ANNUAL DEDUCTIBLE Individual Family	\$200 per person <sup>2</sup> \$400 per family		None	None
COINSURANCE	95%	75%	100%	100%
OUT-OF-POCKET MAXIMUM Individual Family	\$2,000 \$2,000	\$3,750 \$3,750	None	None
HOSPITAL AND EMERGENCY ROOM TRANSPORT	30% of the allowable charge		Up to a \$500 maximum benefit for ground ambulance; up to a \$4,000 maximum benefit for air ambulance	No charge
INPATIENT	\$250 deductible per admission; <sup>3</sup>		\$150 copay per admission	Paid in full
	100% coinsurance after per admission deductible	70% coinsurance after per admission deductible		
INPATIENT PHYSICIAN CARE	95% coinsurance after the \$200 calendar year deductible	75% coinsurance after the \$200 calendar year deductible	Paid in full	Paid in full
OUTPATIENT FACILITY CARE	After \$200 calendar year deductible, plan pays in full, subject to \$25 (PPO) or \$100 (Member facility) copayment per facility per day	After \$200 calendar year deductible, plan pays in full, subject to \$150 copayment per facility per day	\$75 copay per emergency room visit; \$25 copay per physician emergency room visit	\$10 copay each visit; \$50 copay for emergency services received inside the service area from non-plan providers
OUTPATIENT SURGERY	Plan pays in full, subject to \$25 (PPO) or \$100 (Member facility) copayment	Plan pays in full, subject to \$150 copayment	\$10 copay per visit	\$10 copay per visit
ACCIDENTAL INJURY	Plan pays 100% of covered charges within 72 hours		Paid same as illness	Paid same as illness
MEDICAL OFFICE OR HOME VISIT	outpatient office visit charge	the \$200 calendar year deductible	\$10 copay per visit	\$10 copay per visit
LABORATORY & X-RAY SERVICES	Covered at outpatient facility care rates for X-ray, laboratory, pathological services, and machine diagnostic tests		Paid in full	Paid in full
ALLERGY TESTS, TEST MATERIALS, AND TREATMENT MATERIALS	After the \$200 calendar year deductible, plan pays 95% (PPO) or 75% (PAR or non-participating physician)		\$10 copay per visit	\$10 copay per visit
PREVENTIVE CARE	Paid at outpatient facility care rates for cervical cancer screening, mammogram for breast cancer screening, fecal occult blood test for colorectal cancer screening, PSA for prostate cancer screening, tetanus-diphtheria booster, and immunization for influenza and pneumonia		\$5 copay for certain services <sup>4</sup> ; no payment required for routine mammograms according to age-specific guidelines or prostate screening	Immunizations medically indicated and consistent with accepted medical practice are provided without charge

<sup>1</sup> The non-PPO benefits are the standard benefits of this plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

<sup>2</sup> Calendar year deductible applies to all covered services and supplies except for certain inpatient hospital benefits, facility benefits – outpatient surgery, additional benefits, prescription drug benefits, and dental benefits.

<sup>3</sup> Must be precertified; benefits will be reduced by \$500 if emergency admission is not precertified within two business days following the day of admission;

<sup>4</sup> Immunizations as recommended by American Academies of Pediatrics and Family Physicians, routine gynecological exams twice each year, age-specific routine physical examinations, and routine vision examinations.

Benefit Category			1997 Colorado State Employee Coverage – Exclusive Path	HMO Plan – Kaiser Permanente Plan 710
	PPO	Non-PPO		
WELL CHILD CARE	For children up to age 22, plan pays 100% of the allowable charge for all healthy newborn inpatient physician visits, and routine physical exams, lab tests, immunizations, and related office visits as recommended by the American Academy of Pediatrics		\$5 copay for certain services	\$10 copay per visit
MATERNITY CARE Prenatal	Plan pays in full	After the \$200 calendar year deductible, plan pays 75%	E10 copay per office visit	E 10 copay per office visit
Delivery & inpatient well baby care	Pays in full for unlimited days with no per admission deductible (PPO hospital) or after \$250 per admission deductible (Member hospital)	After the \$250 per admission deductible, plan pays 70%	E 150 copay per admission	No charge
INFERTILITY DIAGNOSIS AND TREATMENT	95% coinsurance after the \$200 calendar year deductible	75% coinsurance after the \$200 calendar year deductible	E 10 copay per office visit; covered up to \$2,500 per calendar year <sup>5</sup>	Medical services are provided with \$10 copay per visit. Artificial insemination is covered, except for donor semen, donor eggs, and services related to procurement and storage. All other services related to conception by artificial means, prescription drugs related to such services are not covered. <sup>6</sup> Infertility drugs covered with a 50% charge
ABORTION	Benefits will not be paid for procedures, services, drugs, and supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of rape or incest		Covered only if there is a medical condition that threatens the mother's life if the pregnancy continues, a lethal medical condition in the unborn child that would cause the death of the unborn child during pregnancy or at birth, or a psychiatric condition that may seriously threaten the mother's life if the pregnancy continues to term	

<sup>5</sup> Covers artificial insemination in vivo. Does not cover any cost associated with donor sperm or any other service, supply, or drug used with or for an artificially induced pregnancy, such as “test tube” fertilization, drug-induced ovulation, or other artificial means of conception.

<sup>6</sup> Does not cover in vitro fertilization, ovum transplants, gamete intrafallopian transfer, and zygote intrafallopian transfer.

Benefit Category	PPO	Non-PPO	1997 Colorado State Employee Coverage – Exclusive Path	HMO Plan – Kaiser Permanente Plan 710
ALL OTHER MENTAL HEALTH				
Inpatient care	After a \$150 (PPO) or \$250 (Member hospital) copayment, plan pays the remainder up to 100 days	After a \$400 per day copayment, plan pays the remainder of the cost up to 100 days	150 copayment, then 100% up to 45 days per calendar year	– 20 days, no charge; 21 – 45 days, 50%
Inpatient physician visits				No charge
Outpatient facility care	After the \$200 calendar year deductible, plan pays in full, subject to 25% (PPO) or \$100 copayment	After the \$200 calendar year deductible, plan pays in full, subject to \$150 copayment		
Professional care			\$10 copayment per visit, then 100%	– 10 visits, \$10 each visit; 11 or more visits, \$25 each visit
ALCOHOL & SUBSTANCE ABUSE	Inpatient: one treatment program (28-day maximum) per person per lifetime; covered at the same levels as hospital care and inpatient visits for mental conditions; outpatient also subject to the same levels as mental conditions		Same as mental health	Inpatient detoxification: same as other hospitalization. Inpatient rehab: only evaluation and referral are covered. Outpatient: 50% covered up to \$650 per 12 month period
ORGAN TRANSPLANTS	After the \$200 calendar year deductible, plan pays 75% (PPO) or 75% (PAR or non-participating) <ul style="list-style-type: none"><li>Allogeneic bone marrow<sup>7</sup></li><li>Autologous bone marrow and autologous peripheral stem cell support<sup>8</sup></li><li>Allogeneic bone marrow and allogeneic peripheral stem cell support for multiple myeloma and autologous bone marrow and autologous peripheral stem cell support<sup>7</sup></li><li>Single or double lung transplants for end-stage pulmonary diseases<sup>9</sup></li><li>Cornea</li><li>Kidney</li><li>Heart</li><li>Liver</li><li>Heart-lung</li><li>Pancreas</li></ul>		100% of covered expenses, including organ procurement and acquisition. <sup>11</sup> Kidney and cornea require a \$10 copay per office visit and a \$150 per admission hospital copay <ul style="list-style-type: none"><li>Heart</li><li>Heart-lung</li><li>Kidney-pancreas</li><li>Pancreas</li><li>Liver</li><li>Bone marrow (allogeneic and autologous)<sup>12</sup></li><li>Peripheral blood stem cell</li><li>Kidney</li><li>Cornea</li></ul> Travel expenses for transportation, lodging and meal expenses at 100% up to a total maximum of \$10,000 for a child transplant recipient <sup>13</sup>	Covered transplants are: <ul style="list-style-type: none"><li>Kidney</li><li>Heart</li><li>Heart-lung</li><li>Liver</li><li>Lung</li><li>Cornea</li><li>Kidney/pancreas</li><li>Bone marrow transplants associated with high dose chemotherapy for germ cell tumors and neuroblastoma in children are covered.</li><li>Bone marrow transplants associated with high dose chemotherapy for other solid tissue tumors are not covered</li></ul>

<sup>7</sup> For acute lymphocytic or nonlymphocytic leukemia, advanced Hodgkin’s lymphoma, advanced non-Hodgkin’s lymphoma, advanced neuroblastoma, chronic myelogenous leukemia, infantile malignant osteopetrosis, severe combined immunodeficiency, Wiskott-

Benefit Category	1997 FEHBP – Standard BCBS PPO Plan		1997 Colorado State Employee Coverage – Exclusive Path	HMO Plan – Kaiser Permanente Plan 710
	PPO	Non-PPO <sup>7</sup>		
DURABLE MEDICAL EQUIPMENT	After \$200 calendar year deductible, plan pays 75% for rental or purchase of durable medical equipment, wheelchairs, hospital beds, crutches, orthopedic braces, prosthetic appliances, and one bra per person per calendar year for use with an external breast prosthesis		Covered at 100%, no annual maximum; includes artificial arms, legs, or eyes, leg braces, arm and back braces, maxillofacial prosthesis, cervical collars, surgical implants, oxygen and Equipment needed to administer it, and insulin pumps and related supplies	Covered with 20% copayment, including oxygen and orthotic and prosthetic devices
PHYSICAL AND OCCUPATIONAL THERAPY	After \$200 calendar year deductible, plan pays 75% up to 50 visits for physical therapy and 25 visits for occupational and speech therapy per person per calendar year		\$10 copay per visit for independent therapists; no payment required for hospital outpatient therapy	\$10 copay per visit, up to 2 months per condition, or up to 30 visits per condition if not received within 2 months
HOME HEALTH CARE	After the \$200 calendar year deductible, plan pays 75% for home nursing care for up to 2 hours per day up to 25 visits per calendar year		Paid at 100%, up to 60 visits per year	No charge
HOSPICE CARE	Home Plan pays in full for member with life expectancy of six months or less for physician visits, nursing care, medical social services, physical therapy, services of home health aides, durable medical equipment rental, prescription drugs, and medical supplies		Paid at 100%, \$8,100 benefit payment limit during a 3-month period. Paid at no less than \$91 per day	No charge
	Hospital Up to 5 consecutive days if receiving home hospice care; must be separated by at least 21 days and is paid in full with no (PPO) or \$250 (Non-member hospital) per admission deductible		Paid at 100%, after \$150 per admission copayment, up to 30 days	No charge
	Bereavement Support Not covered		Up to \$1,053 per family per calendar year	No charge
OUTPATIENT PRESCRIPTION DRUGS	\$50 per person annual deductible, then 80% coinsurance; \$100 family annual deductible; \$12 per prescription copay for mail service prescription drug program <sup>14</sup>	\$50 per person annual deductible, then 60% coinsurance; \$100 family annual deductible	\$10 generic, \$15 brand name plus cost difference between brand and generic if generic is available and not prescribed “dispense as written.” \$10 per brand name if no generic equivalent exists	\$5 copay per prescription for up to a 60-day supply.

Aldrich syndrome, mucopolysaccharidosis, mucopolipidosis, severe or very severe aplastic anemia, advanced forms of myelodysplastic syndromes, and thalassemia major.

<sup>8</sup> For acute lymphocytic or nonlymphocytic leukemia, advanced Hodgkin’s lymphoma, advanced non-Hodgkin’s lymphoma, advanced neuroblastoma, testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors, and multiple myeloma.

<sup>9</sup> For breast cancer and epithelial ovarian cancer, only when performed as part of a clinical trial that meets the requirements and is conducted at a cancer research facility.

<sup>10</sup> Pulmonary fibrosis, primary pulmonary hypertension, and emphysema; double lung transplant for end-stage cystic fibrosis.

<sup>11</sup> Does not cover solid organ transplant in patients with an existing or recent malignancy, excluding hepatomas less than 5 cm in diameter, or patients with carcinoma.

<sup>12</sup> Does not cover bone marrow transplantation (allogeneic and autologous) for melanomas, colon cancers, AIDS, certain brain tumors, testicular cancer, sarcomas, lung cancer, ovarian cancer, and peripheral neuroepithelioma. Does not cover autologous bone marrow transplant and peripheral blood stem cell transplant for chronic myelogenous leukemia, multiple myeloma, or brain metastases.

<sup>13</sup> Covers expenses incurred by both the child transplant recipient and up to two adults accompanying the transplant recipient.

<sup>14</sup> Drugs obtained through the mail service prescription drug program are not subject to any deductible.

Benefit Category			1997 Colorado State Employee Coverage – Exclusive Path	HMO Plan – Kaiser Permanente Plan 710
	PPO	Non-PPO <sup>1</sup>		
CONTRACEPTIVE DEVICES AND DRUGS	<ul style="list-style-type: none"><li>IUDs, Norplant, Depo-Provera, and oral contraceptives obtained from a physician are covered at <b>95%</b> or <b>75%</b> after \$200 deductible</li><li>IUDs, Norplant, Depo-Provera, and oral contraceptives dispensed by a retail pharmacy are covered as prescription drugs</li><li>Oral contraceptives are also covered under the mail service prescription drug program</li></ul>		The plan covers oral contraceptives, birth control shots, and certain contraceptive devices and their insertion. Does not cover Norplant device and related expenses	Oral contraceptives are covered. Norplant is covered at a charge of \$200, with no refund if the drug is removed. Contraceptive devices are provided at reasonable charges
SKILLED NURSING FACILITY CARE	When Medicare <b>Part A</b> is primary, plan provides secondary benefits for Medicare Part A copayment incurred in full during the 1 <sup>st</sup> through 30 <sup>th</sup> day		Not covered	No charge up to 100 days per calendar year
VISION SERVICES	After \$200 deductible, plan pays 75% for one set of eyeglasses or contact lenses required as a result of a single instance of intra-ocular surgery or injury		Routine eye exams covered at 100% after a \$5 office copayment, once every 24 months. No allowance for lenses/ frames. One set of prescription eyeglasses or contact lenses are covered when needed to replace human lenses absent at birth or lost through intra-ocular surgery or eye injury or for treatment for keratoconus	\$10 copay per visit for eye exams for glasses; each 24 months, one pair of lenses, frames up to \$65, contact lenses up to \$100
HEARING SERVICES			Hearing exams paid at 100%, after a \$5 copayment. Up to \$500 hearing aid allowance once every 3 years	Hearing exams covered with \$10 copay per visit
DENTISTRY	Oral and maxillofacial surgery, limited to listed procedures <sup>15</sup> . Plan pays 75% after \$200 calendar year deductible for services, supplies, or appliances for accidental injury to sound natural teeth; scheduled amount for other dental care		Covered only if treated in a hospital or other facility on either an inpatient or outpatient basis for certain conditions. <sup>16</sup> Benefits based on surgery benefits	Coverage <b>is not</b> provided for dental care and x-rays, dental services following accidental injury to teeth, dental appliances, orthodontia, and dental services associated with medical treatment. Coverage <b>is</b> provided for medically necessary services for the treatment of cleft lip or palate for newborn members, unless the member is covered for these services under a dental insurance policy
LIFETIME MAXIMUM	Only for smoking cessation and substance abuse		None	None
SMOKING CESSATION TREATMENT PROGRAM	\$100 per person per lifetime for one program		Not covered	Covered with a reasonable charge

<sup>15</sup> Excision of tumors and cysts, surgery needed to correct accidental injuries, excision of exostoses of jaws and hard palate, external incision and drainage of cellulitis, incision and surgical treatment of accessory sinuses, salivary glands or ducts, reduction of dislocations and excision of temporomandibular joints, and removal of impacted teeth.

<sup>16</sup> Excision of exostoses of the jaw, surgical correction of accidental injuries, incision and drainage of cellulitis, incision of accessory sinuses, salivary glands, or ducts, tumors of the jaw, accident-related dental expenses, orthognathic surgery when required because of a malocclusion of the jaw, and TMJ-related services up to \$1,000 per calendar year.

Benefit Category			1997 Colorado State Employee Coverage – Exclusive Path	HMO Plan – Kaiser Permanente Plan 710
	PPO	Non-PPO*		
XCLUSIONS	<div>health insurance coverage</div> <div>Furnished without charge</div> <div>While in active military service</div> <div>Sustained <b>as</b> result of act of war or during combat</div> <div>Furnished by immediate relatives or household members</div> <div>Furnished by provider barred from FEHBP program</div> <div>Furnished by a non-covered facility, except that medically necessary prescription <b>drugs</b> are covered</div> <div>For or related to sex transformation, sexual dysfunction, or sexual inadequacy</div> <div>Not specifically listed <b>as</b> covered</div> <div>Experimental or investigational, except for the clinical trials benefit</div> <div>Not provided in accordance with accepted professional medical standards in the <b>U.S.</b></div> <div>Any portion of fee that has been waived</div> <div>Charges the enrollee or plan has <b>no</b> legal obligation <b>to pay</b></div> <div>In the case of inpatient care, medical services which are not medically <b>necessary</b></div> <div>Standby physicians</div> <div>Biofeedback and other forms of self-care or self-help training, including cardiac rehab</div> <div>Orthodontic care, the teeth, dental implants, periodontal disease, or preparing the mouth for dentures</div> <div>Custodial care</div> <div>Services and supplies furnished or billed by an extended care facility, nursing home, or other non-covered facility, except <b>as</b> specifically described</div> <div>Eyeglasses, contact lenses, routine eye exams or vision testing for the prescribing or fitting of eyeglasses or contact lenses</div> <div><b>Eye</b> exercises, visual training, or orthoptics, except for non-surgical treatment of amblyopia and strabismus</div> <div>Hearing aids or examinations for the prescribing or fitting of hearing aids</div> <div>Treatment of obesity, weight reduction, or dietary control, except for gastric bypass surgery or gastric stapling procedures</div> <div>Personal comfort items such <b>as</b> beauty and barber services, radio, television, or telephone</div> <div>Services or supplies for cosmetic purposes</div> <div>Routine services, except for those preventive services specifically identified</div> <div>Routine foot care</div> <div>Recreational or educational therapy</div> <div>Assisted Reproductive Technology procedures, such <b>as</b> artificial insemination, in vitro fertilization, embryo transfer, and <b>GIFT</b></div> <div>Services rendered by non-covered providers such <b>as</b> chiropractors, except in medically under-served areas</div> <div>Procedures, services, <b>drugs</b>, and supplies related to abortions, except when the life of the mother would be endangered or result of rape or incest</div> <div>Inpatient private duty nursing</div> <div>Radial keratotomy</div> <div>Reversal of surgical sterilization</div> <div>Marital, family, educational, or other counseling or training services</div>	<div>Biofeedback</div> <div>Custodial <i>care</i></div> <div>Maintenance care</div> <div>Any care that is not preauthorized</div> <div>Hypnosis or hypnotherapy treatment</div> <div>Any treatment that is not medically necessary</div> <div>Treatments considered experimental and/or investigational and/or unproven</div> <div>Treatment of nicotine or caffeine addiction</div> <div>Services and related expenses for weight loss program</div> <div>Nutritional supplements</div> <div>Acupuncture</div> <div>Genetic counseling</div> <div>Norplant device and related expenses</div> <div>Rehabilitation for learning disorders, stuttering, short- and long-term memory therapy, or behavior modification</div> <div>Cognitive therapy services.</div> <div>Personal comfort and convenience items</div> <div>Cosmetic surgery</div> <div>Sex-change operations</div> <div>Sterilization reversal</div> <div>Radial keratotomy</div> <div>Attention deficit disorder</div> <div>Biofeedback</div> <div>Chiropractic services</div> <div>Hair loss</div> <div>Private duty nursing</div> <div>Skilled nursing facilities</div> <div>Workers' Comp</div>	<div>Workers Comp or employer responsibility</div> <div>Custodial or intermediate level <b>care</b></div> <div>Cosmetic services</div> <div>Dental services and X-rays including services following accidental injury to teeth or surgery on the jaw</div> <div>Physical <b>exams</b> for employment or insurance</div> <div>Experimental or investigational services</div> <div>Services not generally and customarily available</div> <div>Sex transformations</div> <div>Routine foot care not medically necessary</div> <div>Chiropractic services</div> <div>Services for members confined in criminal justice institutions</div> <div>Refractive eye surgery</div> <div>Long-term rehabilitation</div> <div>Pulmonary rehabilitation</div> <div>Food products for enteral feedings</div> <div>Directed blood donations</div> <div>Reversal of voluntary, surgically induced infertility</div>	

Child Health Plan Plus  
Colorado Benefit Plans

Benefit Category	Fee-For-Service Plan	HMO Plan Families < 150% FPL	HMO Plan Families > 150% FPL
ANNUAL DEDUCTIBLE Individual Family	None	None	None
COINSURANCE	100%	100%	100%
OUT-OF-POCKET MAXIMUM Individual Family	None	None	None
HOSPITAL EMERGENCY ROOM AND EMERGENCY TRANSPORT (COMBINED)	\$15 copay emergency room; emergency transport not covered	\$15 copay, waived if admitted	\$15 copay, waived if admitted
INPATIENT	Paid in full	Paid in full	Paid in full
INPATIENT PHYSICIAN CARE	Paid in full	Paid in full	Paid in full
OUTPATIENT FACILITY CARE	Paid in full	Paid in full	Paid in full
OUTPATIENT SURGERY	Paid in full	Paid in full	Paid in full
ACCIDENTAL INJURY	Paid same as illness	Paid same as illness	Paid same as illness
MEDICAL OFFICE OR HOME VISIT	\$2 copay per visit	\$2 copay per visit	\$5 copay per visit
LABORATORY & X-RAY SERVICES	Paid in full	Paid in full	Paid in full
ALLERGY TESTS, TEST MATERIALS, AND TREATMENT MATERIALS	\$2 copay per visit	\$2 copay per visit	\$5 copay per visit
PREVENTIVE CARE	Paid in full	Paid in full	Paid in full
WELL CHILD CARE	Paid in full	Paid in full	Paid in full
MATERNITY CARE Prenatal	Paid in full	Paid in full	Paid in full
Delivery & inpatient well baby care	Paid in full	Paid in full	Paid in full
INFERTILITY DIAGNOSIS AND TREATMENT	\$2 copay per visit	\$2 copay per visit	\$5 copay per visit
ABORTION	Covered only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest	Covered only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest	Covered only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest
ALL OTHER MENTAL HEALTH Inpatient care	Paid if full up to 45 days per calendar year	Paid if full up to 45 days per calendar year	Paid if full up to 45 days per calendar year
Outpatient care	\$2 copay, 20 visit limit	\$2 copay, 20 visit limit	\$5 copay, 20 visit limit
ALCOHOL & SUBSTANCE ABUSE	Diagnosis, medical treatment and referral services, as defined by Guidelines for Adolescent Preventive Services; alcohol and substance abuse treatment is not covered	Diagnosis, medical treatment and referral services, as defined by Guidelines for Adolescent Preventive Services; alcohol and substance abuse treatment is not covered	Diagnosis, medical treatment and referral services, as defined by Guidelines for Adolescent Preventive Services; alcohol and substance abuse treatment is not covered

Benefit Category	Fee-For-Service Plan	HMO Plan Families < 150% FPL	HMO Plan Families > 150% FPL
ORGAN TRANSPLANTS	Not covered	Covered transplants are: <ul style="list-style-type: none"><li>▪ Liver</li><li>▪ Heart</li><li>▪ Heart/lung</li><li>▪ Cornea</li><li>▪ Kidney</li><li>▪ Bone marrow for aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and stage III breast cancer, and Wiscott Aldrich syndrome</li><li>▪ Peripheral stem cell support for same conditions</li></ul>	Covered transplants are: <ul style="list-style-type: none"><li>▪ Liver</li><li>▪ Heart</li><li>▪ Heart/lung</li><li>▪ Cornea</li><li>▪ Kidney</li><li>▪ Bone marrow for aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and stage III breast cancer, and Wiscott Aldrich syndrome</li><li>▪ Peripheral stem cell support for same conditions</li></ul>
DURABLE MEDICAL EQUIPMENT	Paid in full up to \$2,000 per year	Paid in full up to \$2,000 per year	Paid in full up to \$2,000 per year
PHYSICAL AND OCCUPATIONAL THERAPY	\$2 copay, up to 30 visits per year	\$2 copay, up to 30 visits per year	\$5 copay, up to 30 visits per year
HOME HEALTH CARE	No charge	No charge	No charge
HOSPICE CARE	Not covered	Paid in full	Paid in full
OUTPATIENT PRESCRIPTION DRUGS	\$2 copay per prescription	\$1 copay per prescription	\$3 generic, \$5 brand name copay per prescription
CONTRACEPTIVE DEVICES AND DRUGS	Covered	Covered	Covered
SKILLED NURSING FACILITY CARE	Not covered	Paid in full	Paid in full
VISION SERVICE	\$2 copay per visit, \$50 annual benefit for eyeglasses	\$2 copay per visit, \$50 annual benefit for eyeglasses	\$5 copay per visit, \$50 annual benefit for eyeglasses
HEARING SERVICES	Paid in full, up to \$800 per year	Paid in full, up to \$800 per year	Paid in full, up to \$800 per year
DENTISTRY	Not covered	\$2 copay for preventive services	\$5 copay for preventive services
LIFETIME MAXIMUM	None	None	None
EXCLUSIONS	<ul style="list-style-type: none"><li>▪ Experimental procedures</li><li>▪ Custodial care</li><li>▪ Personal comfort items</li><li>▪ TMJ treatment</li><li>▪ Treatment for obesity</li><li>▪ Acupuncture</li><li>▪ Biofeedback</li><li>▪ In vitro fertilization</li><li>▪ Gamete or zygote intrafallopian transfer</li><li>▪ Artificial insemination</li><li>▪ Reversal of voluntary sterilization</li><li>▪ Transsexual surgery</li><li>▪ Treatment of sexual disorders</li><li>▪ Cosmetic surgery</li><li>▪ Radial keratotomy</li><li>▪ Biofeedback</li><li>▪ Chiropractic services</li><li>▪ Private duty nursing</li><li>▪ Workers' Comp</li><li>▪ Physical exams for employment or insurance</li><li>▪ Routine foot care not medically necessary</li><li>▪ Services for members confined in criminal justice institutions</li><li>▪ Any treatment not medically necessary</li><li>▪ Dental care</li><li>▪ Hospice care</li><li>▪ Transplants</li><li>▪ Emergency transport</li><li>▪ Skilled nursing facility</li><li>▪ Autism</li></ul>	<ul style="list-style-type: none"><li>▪ Experimental procedures</li><li>▪ Custodial care</li><li>▪ Personal comfort items</li><li>▪ TMJ treatment</li><li>▪ Treatment for obesity</li><li>▪ Acupuncture</li><li>▪ Biofeedback</li><li>▪ In vitro fertilization</li><li>▪ Gamete or zygote intrafallopian transfer</li><li>▪ Artificial insemination</li><li>▪ Reversal of voluntary sterilization</li><li>▪ Transsexual surgery</li><li>▪ Treatment of sexual disorders</li><li>▪ Cosmetic surgery</li><li>▪ Radial keratotomy</li><li>▪ Biofeedback</li><li>▪ Chiropractic services</li><li>▪ Private duty nursing</li><li>▪ Workers' Comp</li><li>▪ Physical exams for employment or insurance</li><li>▪ Routine foot care not medically necessary</li><li>▪ Services for members confined in criminal justice institutions</li><li>▪ Any treatment not medically necessary</li></ul>	<ul style="list-style-type: none"><li>▪ Experimental procedures</li><li>▪ Custodial care</li><li>▪ Personal comfort items</li><li>▪ TMJ treatment</li><li>▪ Treatment for obesity</li><li>▪ Acupuncture</li><li>▪ Biofeedback</li><li>▪ In vitro fertilization</li><li>▪ Gamete or zygote intrafallopian transfer</li><li>▪ Artificial insemination</li><li>▪ Reversal of voluntary sterilization</li><li>▪ Transsexual surgery</li><li>▪ Treatment of sexual disorders</li><li>▪ Cosmetic surgery</li><li>▪ Radial keratotomy</li><li>▪ Biofeedback</li><li>▪ Chiropractic services</li><li>▪ Private duty nursing</li><li>▪ Workers' Comp</li><li>▪ Physical exams for employment or insurance</li><li>▪ Routine foot care not medically necessary</li><li>▪ Services for members confined in criminal justice institutions</li><li>▪ Any treatment not medically necessary</li></ul>

Child Health Plan Plus  
Standardized Utilization and Cost Factors

	Standardized Utilization				Standardized Cost			
	0 - 1	2 - 6	7 - 18	Combined	0 - 1	2 - 6	7 - 18	Combined
Categories of Basic Services								
Inpatient Hospital								
Medical/Surgical	0.6480	0.0795	0.0835	0.1384	\$2,618.59	\$ 1,962.05	\$2,125.73	\$2,131.97
Maternity	0.0000	0.0000	0.0012	0.0007	\$ 1,661.22	\$ 1,661.22	\$ 1,661.22	\$ 1,661.22
Outpatient Hospital								
Emergency Room	0.1705	0.1840	0.1915	0.1875	\$ 285.08	\$ 285.08	\$ 285.08	\$ 285.08
Surgery	0.0409	0.0428	0.0279	0.0331	\$2,346.81	\$2,346.81	\$2,346.81	\$2,346.81
Other	0.0000	0.3891	0.1089	0.1711	\$ 176.73	\$ 176.73	\$ 176.73	\$ 176.73
Physician								
Inpatient Surgery	0.0459	0.0094	0.0136	0.0157	\$ 1,229.10	\$ 1,662.66	\$ 1,735.79	\$ 1,666.62
Outpatient Surgery	0.1501	0.1328	0.1831	0.1668	\$ 390.91	\$ 373.60	\$ 235.15	\$ 286.57
Office Visits and Misc	5.8634	3.1907	1.8037	2.5662	\$ 59.74	\$ 58.26	\$ 61.28	\$ 60.34
Hospital Visits	0.5235	0.0595	0.1578	0.1685	\$ 179.78	\$ 153.18	\$ 141.88	\$ 148.57
Emergency Room Visits	0.1744	0.1620	0.1486	0.1547	\$ 125.65	\$ 115.90	\$ 101.22	\$ 107.45
Maternity Care	0.0000	0.0000	0.0004	0.0003	\$2,919.51	\$2,919.51	\$2,919.51	\$2,919.51
Other	0.1329	0.0177	0.0154	0.0276	\$ 165.73	\$ 163.84	\$ 167.56	\$ 166.41
Laboratory and X-Ray Services								
Radiology/Pathology Facility Services	0.1323	0.0813	0.0951	0.0952	\$ 376.90	\$ 376.90	\$ 376.90	\$ 376.90
Radiology/Pathology Physician Services	1.7186	1.2825	1.1491	1.2401	\$ 33.26	\$ 37.34	\$ 40.27	\$ 38.81
Well Child Services								
Immunizations	2.93 11	1.0148	0.2033	0.6843	\$ 32.55	\$ 32.55	\$ 32.55	\$ 32.55
Well Baby Exams	3.2099	0.0000	0.0000	0.3 178	\$ 68.55	\$ 6.46	\$ 68.55	\$ 52.41
Well Child Exams	0.0000	0.1021	0.1500	0.1227	\$ -	\$ 99.58	\$ 149.34	\$ 121.62
Categories of Additional Services								
Prescription Drugs	4.1778	2.8195	1.6975	2.2347	\$ 24.33	\$ 31.00	\$ 42.66	\$ 37.81
Mental Health Services								
Inpatient	0.0000	0.0035	0.0730	0.0477	\$ 1,339.47	\$ 1,339.47	\$ 1,339.47	\$ 1,339.47
Outpatient	0.0000	0.0644	0.2070	0.1494	\$ 128.50	\$ 128.50	\$ 128.50	\$ 128.50
Vision Services								
Vision Exams	0.0248	0.0754	0.1766	0.1353	\$ 74.35	\$ 74.35	\$ 74.35	\$ 74.35
Glasses/Contacts	0.0000	0.0285	0.0699	0.0522	\$ 213.37	\$ 213.37	\$ 213.37	\$ 213.37
Hearing Services								
Hearing Exams	0.0018	0.1003	0.0322	0.0469	\$ 57.59	\$ 57.59	\$ 57.59	\$ 57.59
Hearing Aids	0.0000	0.0070	0.0070	0.0063	\$ 1,000.00	\$ 1,000.00	\$ 1,000.00	\$ 1,000.00
Other Categories of Services								
Substance Abuse Inpatient	0.0000	0.0000	0.0206	0.0132	\$ 980.60	\$ 980.48	\$ 980.48	\$ 980.49
Substance Abuse Outpatient	0.0000	0.0000	0.0064	0.004 1	\$ 113.40	\$ 113.40	\$ 113.40	\$ 113.40
Skilled Nursing Facility	0.0000	0.0000	0.001 1	0.0007	\$ 406.31	\$ 406.3 1	\$ 406.31	\$ 406.3 1
Chiropractor	0.0187	0.0383	0.1380	0.1002	\$ 64.38	\$ 64.38	\$ 64.38	\$ 64.38
Physical Therapy	0.0454	0.0757	0.0774	0.0738	\$ 68.16	\$ 68.16	\$ 68.16	\$ 68.16
Home Health	0.0175	0.033 1	0.0092	0.0162	\$ 278.50	\$ 278.50	\$ 278.50	\$ 278.50
Ambulance	0.0212	0.0064	0.0074	0.0085	\$ 393.48	\$ 393.48	\$ 393.48	\$ 393.48
Durable Medical Equipment	0.0405	0.0221	0.0221	0.0239	\$ 328.93	\$ 328.93	\$ 328.93	\$ 328.93
Audiology Exams	0.0000	0.0018	0.0018	0.0017	\$ 91.93	\$ 93.43	\$ 115.67	\$ 107.54
Dental Care	0.0000	3.0010	3.0010	2.7039	\$ 72.74	\$ 72.74	\$ 72.74	\$ 72.74

Child Health Plan Plus  
Standardized Population

<i>Age</i>	<i>Projected 1997 Colorado Population</i>
<b>0</b>	53,107
1	52,777
2	54,040
3	54,375
<b>4</b>	55,875
<b>5</b>	57,106
6	57,295
7	57,769
8	54,393
9	57,578
10	58,257
11	57,685
12	57,100
13	56,528
<b>14</b>	57,943
15	58,539
16	57,654
17	58,276
18	53,920
Total	1,070,217

# An Act

HOUSE BILL 97-1304

BY REPRESENTATIVES Owen, Dyer, Bacon, Chavez, Clarke, Gotlieb, Hagedorn, Keller, Leyba, Mace, Miller, Nichol, Romero, Schwarz, Snyder, Tate, Tool, Tucker, Tupa, Udall, Veiga, S. Williams, and Zimmerman; also SENATORS Hopper, Hernandez, Martinez, Pascoe, Reeves, Rupert, Tanner, and Wham.

CONCERNING THE CREATION OF THE CHILDREN'S BASIC HEALTH PLAN, AND  
MAKING AN APPROPRIATION IN CONNECTION THEREWITH.

*Be it enacted by the General Assembly of the State of Colorado:*

**SECTION 1.** Title 26, Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW ARTICLE to read:

## **ARTICLE 19** **Children's Basic Health Plan**

**26-19-101. Short title.** THIS ARTICLE SHALL BE KNOWN AND MAY BE CITED AS THE "CHILDREN'S BASIC HEALTH **PLAN ACT**".

**26-19-102. Legislative declaration.** (1) THE GENERAL ASSEMBLY HEREBY FINDS AND DECLARES THAT A SIGNIFICANT PERCENTAGE OF CHILDREN ARE UNINSURED. THIS LACK OF HEALTH INSURANCE COVERAGE DECREASES CHILDREN'S ACCESS TO PREVENTIVE HEALTH CARE SERVICES, COMPROMISES ~~THE~~ PRODUCTIVITY OF THE STATE'S FUTURE WORKFORCE, AND

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Capital letters indicate new material added to existing statutes; dashes through words indicate deletions from existing statutes and such material not **part** of act.

RESULTS IN AVOIDABLE EXPENDITURES FOR EMERGENCY AND REMEDIAL HEALTH CARE. HEALTH CARE PROVIDERS, HEALTH CARE FACILITIES, AND ALL PURCHASERS OF ~~HEALTH~~ CARE, INCLUDING THE STATE, BEAR THE COSTS OF THIS UNCOMPENSATED CARE.

(2) THE GENERAL ASSEMBLY FURTHER FINDS AND DECLARES THAT THE COORDINATION AND CONSOLIDATION OF FUNDING SOURCES CURRENTLY AVAILABLE TO PROVIDE SERVICES TO UNINSURED CHILDREN SUCH ~~AS~~ THE CHILDREN'S HEALTH PLAN CREATED IN ARTICLE 17 OF THIS TITLE, THE COLORADO INDIGENT CARE PROGRAM PURSUANT TO ARTICLE 15 OF THIS TITLE, AND OTHER CHILDREN'S ~~HEALTH~~ PROGRAMS WOULD EFFICIENTLY AND EFFECTIVELY ~~MEET~~ THE HEALTH CARE NEEDS OF UNINSURED CHILDREN AND WOULD HELP TO REDUCE THE VOLUME OF UNCOMPENSATED CARE IN THE STATE.

(3) (a) IT IS THE INTENT OF THE GENERAL ASSEMBLY TO MAKE HEALTH INSURANCE COVERAGE AFFORDABLE AND TO SUPPORT EMPLOYERS IN THEIR EFFORTS TO PROVIDE THEIR EMPLOYEES AND THEIR DEPENDENTS WITH HEALTH INSURANCE COVERAGE.

(b) IT ~~IS~~ THE INTENT OF THE GENERAL ASSEMBLY THAT THE CHILDREN'S BASIC HEALTH PLAN CREATED BY THIS ARTICLE BE PRIMARILY FUNDED THROUGH SAVINGS AND EFFICIENCIES REALIZED THROUGH ACTUAL REDUCTIONS IN ADMINISTRATIVE AND PROGRAMMATIC COSTS ASSOCIATED WITH THE IMPLEMENTATION OF THIS ARTICLE ACHIEVED IN OTHER HEALTH CARE PROGRAMS AND NOT DECREASES ~~IN~~ THE NUMBER OF CASELOADS OF SUCH PROGRAMS.

(4) IT ~~IS~~ NOT THE ~~INTENT~~ OF THE GENERAL ASSEMBLY TO CREATE AN ENTITLEMENT FOR HEALTH INSURANCE COVERAGE.

**26-19-103. Definitions.** AS USED IN THIS ARTICLE, UNLESS THE CONTEXT OTHERWISE REQUIRES:

(1) "CHILD" MEANS A PERSON WHO ~~IS~~ LESS THAN EIGHTEEN YEARS OF AGE.

(2) "CHILDREN'S BASIC HEALTH PLAN" OR "PLAN" MEANS THE HEALTH INSURANCE PRODUCT DESIGNED BY THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING AND PROVIDED TO ENROLLEES, AS DEFINED IN THIS SECTION.

(3) "DEPARTMENT" MEANS THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING CREATED IN SECTION **25.5-1-104, C.R.S.**

(4) "ELIGIBLE PERSON" MEANS A PERSON **WHO** IS LESS THAN EIGHTEEN **YEARS** OF AGE, WHOSE GROSS FAMILY INCOME DOES NOT EXCEED ONE HUNDRED EIGHTY-FIVE PERCENT OF THE **FEDERAL** POVERTY LEVEL, ADJUSTED FOR FAMILY SIZE.

(5) "ENROLLEE" MEANS ANY CHILD THAT HAS ENROLLED IN THE PLAN.

(6) "HEALTHCARE PROGRAM" MEANS ~~ANY~~ HEALTH CARE PROGRAM IN THE STATE THAT IS SUPPORTED WITH STATE GENERAL ~~FUND~~ OR FEDERAL DOLLARS.

(7) "SUBSIDIZED ENROLLEE" MEANS AN ELIGIBLE PERSON WHO RECEIVES A SUBSIDY FROM THE DEPARTMENT TO PURCHASE COVERAGE UNDER THE PLAN OR A COMPARABLE HEALTH INSURANCE.

(8) "SUBSIDY" MEANS THE AMOUNT PAID BY THE DEPARTMENT TO ASSIST AN ELIGIBLE PERSON IN PURCHASING COVERAGE UNDER THE PLAN OR ACOMPARABLE HEALTH INSURANCE PRODUCT AVAILABLE TO THE ELIGIBLE PERSON THROUGH ANOTHER COVERAGE ENTITY.

(9) "TRUST" **MEANS** THE CHILDREN'S BASIC HEALTH PLAN TRUST CREATED IN SECTION **26-19-105.**

**26-19-104. Children's basic health plan - implementation required - rules.** THE DEPARTMENT IS AUTHORIZED TO ADOPT RULES TO IMPLEMENT THE CHILDREN'S BASIC HEALTH PLAN TO PROVIDE HEALTH INSURANCE COVERAGE TO CHILDREN ON **A** STATEWIDE BASIS PURSUANT TO THE PROVISIONS OF THIS ARTICLE.

**26-19-105. Trust - created.** (1) **A** FUND TO BE KNOWN AS THE CHILDREN'S BASIC HEALTH PLAN TRUST IS HEREBY CREATED AND ESTABLISHED IN THE STATE TREASURY. ALL MONEYS DEPOSITED IN THE TRUST AND ALL INTEREST EARNED ON MONEYS IN THE TRUST SHALL **REMAIN** IN THE TRUST FOR THE PURPOSES SET FORTH IN THIS ARTICLE, AND NO PART THEREOF SHALL BE EXPENDED OR APPROPRIATED FOR ANY OTHER PURPOSE. NO INVESTMENT EARNINGS OR OTHER MONEYS IN THE TRUST SHALL BE SUBJECT TO ANY MANAGEMENT FEE IMPOSED BY LAW FOR THE BENEFIT OF

THE GENERAL FUND.

(2) ALL OR A PORTION OF THE MONEYS IN THE TRUST SHALL BE ANNUALLY APPROPRIATED BY THE GENERAL ASSEMBLY FOR THE PURPOSES OF THIS ARTICLE AND SHALL NOT BE TRANSFERRED TO OR REVERT TO THE GENERAL FUND OF THE STATE AT THE END OF ANY FISCAL YEAR.

(3) BEGINNING IN FISCAL YEAR **1998**, APPROPRIATIONS TO THE TRUST MAY BE MADE BY THE GENERAL ASSEMBLY BASED ON THE SAVINGS ACHIEVED THROUGH REFORMS, CONSOLIDATIONS, AND STREAMLINING OF HEALTH CARE PROGRAMS REALIZED THROUGH ACTUAL REDUCTIONS IN ADMINISTRATIVE AND PROGRAMMATIC COSTS ASSOCIATED WITH THE IMPLEMENTATION OF ~~THIS~~ ARTICLE AND NOT DECREASES IN THE NUMBER OF CASELOADS OF SUCH PROGRAMS. BEGINNING WITH AND SUBSEQUENT TO FISCAL YEAR **1999**, THESE APPROPRIATIONS MAY BE BASED ON THE ANNUAL SAVINGS REPORT DESCRIBED IN SECTION **26-19-106**.

(4) AS PART OF ITS ANNUAL SAVINGS REPORT TO THE GENERAL ASSEMBLY ON NOVEMBER **1** OF EACH YEAR, THE DEPARTMENT MAY IDENTIFY EFFICIENCIES AND CONSOLIDATIONS THAT PRODUCE SAVINGS IN THE DEPARTMENT'S ANNUAL BUDGET REQUEST THAT RESULT IN ACTUAL REDUCTIONS IN ADMINISTRATIVE AND PROGRAMMATIC COSTS ASSOCIATED WITH THE IMPLEMENTATION OF THIS ARTICLE AND NOT DECREASES IN THE NUMBER OF CASELOADS OF SUCH PROGRAMS. THESE IDENTIFIED SAVINGS SHALL NOT DUPLICATE THE SAVINGS REPORTED IN THE ANNUAL SAVINGS REPORT DESCRIBED IN SECTION **26-19-106**. IF THE GENERAL ASSEMBLY DETERMINES THAT THE SAVINGS IDENTIFIED PURSUANT TO THIS SUBSECTION **(4)** ARE VALID, IT IS THE INTENT OF THE GENERAL ASSEMBLY THAT SUCH SAVINGS MAY BE APPROPRIATED TO THE CHILDREN'S BASIC HEALTH PLAN TRUST.

(5) THE DEPARTMENT MAY RECEIVE PAYMENT FOR COVERAGE OFFERED AND MAY RECEIVE OR CONTRACT FOR DONATIONS, GIFTS, AND GRANTS FROM ANY SOURCE. SUCH FUNDS SHALL BE TRANSMITTED TO THE STATE TREASURER WHO SHALL CREDIT THE SAME TO THE TRUST. THE DEPARTMENT MAY EXPEND SUCH FUNDS FROM THE TRUST FOR THE PURPOSES OF THIS ARTICLE.

**26-19-106. Annual savings report.** (1) BY NOVEMBER **1** OF EACH YEAR, THE DEPARTMENT SHALL SUBMIT TO THE JOINT BUDGET COMMITTEE OF THE GENERAL ASSEMBLY AND TO THE OFFICE OF STATE PLANNING AND

BUDGETING AN ANNUAL **SAVINGS** REPORT STATING THE COST-**SAVINGS** ANTICIPATED IN THE PREVIOUS, CURRENT, AND SUBSEQUENT FISCAL YEARS FROM HEALTH CARE PROGRAM REFORMS, CONSOLIDATIONS, AND STREAMLINING.

(2) **THE** ANNUAL SAVINGS REPORT SHALL INCLUDE A DESCRIPTION OF NET SAVINGS FACTORING IN INCREASED ADMINISTRATIVE EXPENSES FROM THE FOLLOWING:

(a) **Enrollment of medicaid clients in medicaid managed care programs.** IN CALCULATING SAVINGS FROM ENROLLMENT OF MEDICAID CLIENTS INTO MEDICAID MANAGED CARE PROGRAMS, THE DEPARTMENT SHALL CALCULATE THE TOTAL ANNUAL SAVINGS FROM GROWTH IN MANAGED CARE ENROLLMENT SUBSEQUENT TO JUNE 30, 1997.

(b) **Consolidation of the children's portions of the Colorado indigent care program into the plan.** IN CALCULATING THE SAVINGS ACCRUED AND ANTICIPATED FROM CONSOLIDATION OF THE CHILDREN'S PORTIONS OF THE COLORADO INDIGENT CARE PROGRAM, CREATED IN ARTICLE **15** OF **THIS** TITLE, INTO THE PLAN, THE DEPARTMENT SHALL USE THE FOLLOWING METHODOLOGY: ESTIMATE THE REDUCTION IN EXPENDITURES DUE TO THE REDUCTION IN THE NUMBER OF CHILDREN UNDER AGE EIGHTEEN SERVED BY THE COLORADO INDIGENT CARE PROGRAM FOR EACH FISCAL YEAR IN WHICH CHILDREN HAVE BEEN ENROLLED IN THE CHILDREN'S BASIC HEALTH PLAN.

(3) AS REPORTED IN THE ANNUAL SAVINGS REPORT, THE TOTAL SAVINGS FROM CONSOLIDATION OF THE CHILDREN'S PORTIONS OF THE **COLORADO** INDIGENT CARE PROGRAM, CREATED IN ARTICLE **15** OF THIS TITLE, INTO THE PLAN SHALL NOT REDUCE THE REIMBURSEMENT RATE OF EXPENDITURES MADE ON BEHALF OF CHILDREN TO THE COLORADO INDIGENT CARE PROGRAM ENROLLED PROVIDERS BELOW THE REIMBURSEMENT RATES USED IN THE FISCAL YEAR PRIOR TO THE FIRST CHILD ENROLLING IN THE PLAN.

(4) **THE** DEPARTMENT SHALL MODIFY TOTAL SAVINGS CALCULATED IN PARAGRAPH (b) OF SUBSECTION (2) OF THIS SECTION ACCORDING TO THE GEOGRAPHIC RESIDENCE OF SUBSIDIZED ENROLLEES AND TO THE PROBABLE LOCATION OF THEIR HEALTH CARE PROVIDERS UNDER THE COLORADO INDIGENT CARE PROGRAM, CREATED IN ARTICLE **15** OF **THIS** TITLE.

(5) ~~THE~~ GENERAL ASSEMBLY SHALL MAKE ~~APPROPRIATIONS~~ TO THE TRUST BASED ON ~~THE~~ SAVINGS CALCULATED IN PARAGRAPH (b) OF SUBSECTION (2) OF ~~THIS~~ SECTION TWELVE MONTHS AFTER THE PLAN BEGINS PROVIDING A BENEFIT PACKAGE THAT INCLUDES INPATIENT CARE AND ANNUALLY THEREAFTER.

**26-19-107. Duties of the department - schedule of services - premiums - copayments - subsidies.** (1) IN ADDITION TO ANY OTHER DUTIES PURSUANT TO ~~THIS~~ ARTICLE, THE DEPARTMENT SHALL HAVE THE FOLLOWING DUTIES:

(a) TO DESIGN, ON OR AFTER JULY 1, 1998, AND FROM TIME TO TIME REVISE, A SCHEDULE OF HEALTH CARE SERVICES INCLUDED IN THE PLAN, INCLUDING, BUT NOT LIMITED TO, PREVENTIVE CARE, PHYSICIAN SERVICES, INPATIENT AND OUTPATIENT HOSPITAL SERVICES, PRESCRIPTION DRUGS AND MEDICATIONS, AND OTHER SERVICES THAT MAY BE MEDICALLY NECESSARY FOR THE HEALTH OF ENROLLEES. THE DEPARTMENT SHALL DESIGN AND REVISE THIS SCHEDULE OF HEALTH CARE SERVICES INCLUDED ~~IN~~ THE PLAN TO BE SIMILAR TO THE BASIC AND STANDARD HEALTH BENEFIT PLANS DEFINED IN SECTION 10-16-102(4) AND (42), **C.R.S.**

(b) TO DESIGN AND IMPLEMENT A STRUCTURE OF PERIODIC PREMIUMS DUE TO THE DEPARTMENT OR TO MANAGED CARE PLANS FROM ENROLLEES THAT ~~IS~~ BASED ON A SLIDING FEE SCALE. THE SLIDING FEE SCALE SHALL BE DEVELOPED BASED ON THE PER CAPITA COST OF THE PLAN AND ~~THE~~ ENROLLEE'S GROSS FAMILY INCOME DURING THE PREVIOUS THREE MONTHS. AS PERMITTED BY FEDERAL AND STATE LAW, ENROLLEES IN THE PLAN MAY USE ~~FUNDS~~ FROM A MEDICAL SAVINGS ACCOUNT TO PAY PREMIUMS. ON OR BEFORE NOVEMBER 1 OF EACH YEAR, THE DEPARTMENT SHALL SUBMIT FOR APPROVAL TO THE JOINT BUDGET COMMITTEE ITS PROPOSAL FOR A SCALE FOR INCREASING PREMIUMS OR SERVICE COST SHARING FOR THE PLAN BASED UPON A FAMILY'S INCOME.

(c) TO DESIGN AND IMPLEMENT A STRUCTURE OF COPAYMENTS DUE TO PROVIDERS OF MANAGED HEALTH CARE PLANS FROM ENROLLEES. ENROLLEES IN THE PLAN MAY USE FUNDS FROM A MEDICAL SAVINGS ACCOUNT TO PAY COPAYMENTS.

(d) TO DESIGN DETAILED RULES OF ELIGIBILITY AND ENROLLMENT PROCESSES FOR THE PLAN;

(e) TO DESIGN A PROCEDURE WHEREBY A FINANCIAL SPONSOR MAY PAY THE PREMIUM OR ~~SOME~~ PORTION THEREOF ON BEHALF OF A SUBSIDIZED OR NONSUBSIDIZED ENROLLEE; EXCEPT THAT ~~THE~~ PAYMENT MADE ON BEHALF OF SAID ENROLLEE SHALL NOT EXCEED THE TOTAL PREMIUMS DUE FROM THE ENROLLEE;

(f) TO DESIGN A PROCEDURE WHEREBY THE PLAN MAY PAY SUBSIDIES FOR ELIGIBLE PERSONS TO PURCHASE COVERAGE UNDER THE PLAN OR A COMPARABLE HEALTH INSURANCE PRODUCT;

(g) TO ESTABLISH CRITERIA TO ALLOW A MANAGED CARE PLAN, THE DEPARTMENT, OR ~~SOME~~ OTHER ENTITY TO VERIFY ELIGIBILITY PURSUANT TO SECTION 26-19-109.

(2) ~~THE~~ DEPARTMENT ~~IS~~ AUTHORIZED TO INSTITUTE A PROGRAM FOR COMPETITIVE BIDDING PURSUANT TO SECTION 24- 103-202 OR ~~24-~~ 103-203, **C.R.S.**, FOR PROVIDING MEDICAL SERVICES ON A MANAGED CARE BASIS FOR CHILDREN UNDER THIS ARTICLE. THE DEPARTMENT IS AUTHORIZED TO SELECT MORE THAN ONE MANAGED CARE CONTRACTOR, TO THE EXTENT THAT THE DEPARTMENT DETERMINES THAT THERE IS A UNIQUE COMMUNITY-BASED ORGANIZATION THAT IS ABLE TO PERFORM THE NEW FUNCTIONS REQUIRED UNDER THIS ARTICLE, THE DEPARTMENT MAY SELECT SUCH CONTRACTOR PURSUANT TO SECTION 24-103-205, **C.R.S.** AND RULES PROMULGATED BY THE DEPARTMENT TO ADMINISTER ALL OR A PORTION OF THE CHILDREN'S BASIC HEALTH PLAN ACCORDING TO SECTION 26- 19-111. IN ADDITION TO SUCH CONTRACTOR, THE DEPARTMENT MAY ENTER INTO CONTRACTS, AS NECESSARY, WITH THE ADMINISTRATOR OF ~~THE~~ COLORADO CHILDREN'S HEALTH PLAN TO CARRY ~~OUT~~ THE PURPOSES OF THIS ARTICLE.

**26-19-108. Financial management.** (1) THE DEPARTMENT SHALL PROMULGATE RULES TO IMPLEMENT FINANCIAL MANAGEMENT OF THE PLAN. ~~THE~~ DEPARTMENT SHALL ADJUST BENEFIT LEVELS, ELIGIBILITY GUIDELINES, AND ANY OTHER **MEASURE** TO ENSURE THAT SUFFICIENT FUNDS ARE PRESENT TO IMPLEMENT THE PROVISIONS OF THIS ARTICLE.

(2) THE DEPARTMENT SHALL MAKE A QUARTERLY ASSESSMENT OF THE EXPECTED EXPENDITURES FOR THE PLAN FOR THE REMAINDER OF THE CURRENT BIENNIUM AND FOR THE FOLLOWING BIENNIUM. THE ESTIMATED EXPENDITURES, INCLUDING MINIMUM RESERVE REQUIREMENTS SHALL BE COMPARED TO AN ESTIMATE OF THE REVENUES THAT WILL BE DEPOSITED IN THE TRUST FUND. BASED ON THIS COMPARISON, THE DEPARTMENT SHALL

MAKE ADJUSTMENTS AS NECESSARY TO ENSURE THAT EXPENDITURES REMAIN WITHIN THE LIMITS OF **AVAILABLE REVENUES** FOR THE REMAINDER OF THE CURRENT BIENNIUM AND THE FOLLOWING BIENNIUM.

(3) **THE** DEPARTMENT MAY, IN ADDITION TO ANY OTHER MEASURE IT DETERMINES TO BE NECESSARY, DECREASE PREMIUM SUBSIDIES OR LIMIT ENROLLMENT IN THE PLAN TO ENSURE THAT THE TRUST **RETAINS** SUFFICIENT FUNDS PURSUANT TO SUBSECTION (1) OF THIS SECTION.

(4) NOTHING IN THIS ARTICLE OR ANY RULES PROMULGATED PURSUANT TO THE PLAN SHALL BE INTERPRETED TO CREATE A LEGAL ENTITLEMENT IN ANY PERSON TO COVERAGE UNDER THE PLAN. ENROLLMENT IN THE PLAN SHALL BE LIMITED BASED UPON ANNUAL APPROPRIATIONS MADE **OUT** OF THE TRUST BY THE GENERAL ASSEMBLY AS DESCRIBED IN SECTION **26-19-105** **AND** ANY GRANTS AND DONATIONS. THE GENERAL ASSEMBLY SHALL ANNUALLY ESTABLISH MAXIMUM ENROLLMENT FIGURES FOR SUBSIDIZED CHILDREN. SUCH ENROLLMENT CAPS SHALL NOT BE EXCEEDED BY THE DEPARTMENT REGARDLESS OF WHETHER THE FUNDING COMES FROM ANNUAL APPROPRIATIONS OR GRANTS AND DONATIONS. WHEN ENROLLMENT IN THE PLAN MUST BE LIMITED PURSUANT TO THIS SUBSECTION (4), THE DEPARTMENT SHALL GIVE PRIORITY TO CHILDREN WHO WOULD QUALIFY FOR MEDICAID AS IF THERE WERE NO ASSET TESTING AND TO CHILDREN WITH **GROSS** FAMILY INCOMES UNDER ONE HUNDRED THIRTY-THREE PERCENT OF THE FEDERAL POVERTY LEVEL.

**26-19-109. Eligibility.** (1) TO BE ELIGIBLE FOR A SUBSIDY, A CHILD MUST NOT HAVE CURRENTLY NOR IN THE THREE MONTHS PRIOR TO APPLICATION FOR THE PLAN HAVE BEEN INSURED BY A COMPARABLE HEALTH PLAN THROUGH AN EMPLOYER, WITH THE EMPLOYER CONTRIBUTING AT LEAST FIFTY PERCENT OF THE PREMIUM COST. CHILDREN WHO HAVE LOST INSURANCE COVERAGE DUE TO A CHANGE IN OR LOSS OF EMPLOYMENT SHALL NOT BE SUBJECT TO THE WAITING PERIOD.

(2) IF ONE CHILD FROM A FAMILY IS ENROLLED IN THE PLAN, ALL CHILDREN MUST BE ENROLLED, UNLESS THE OTHER CHILDREN HAVE ALTERNATIVE HEALTH INSURANCE COVERAGE.

(3) CHILDREN WITH GROSS FAMILY INCOMES THAT EXCEED ONE HUNDRED EIGHTY-FIVE PERCENT OF THE FEDERAL POVERTY GUIDELINES MAY ENROLL IN THE PLAN, BUT ARE NOT ELIGIBLE FOR SUBSIDIES FROM THE DEPARTMENT.

(4) CHILDREN **WHO ARE** DETERMINED TO BE ELIGIBLE FOR THE PLAN SHALL REMAIN ELIGIBLE FOR TWELVE MONTHS **SUBSEQUENT** TO THE LAST DAY OF THE MONTH IN WHICH THEY **WERE** ENROLLED.

**26-19-110. Participation by managed care plans.** (1) MANAGED CARE PLANS, AS DEFINED IN SECTION 10-16-102 (26.5), **C.R.S.**, THAT PARTICIPATE IN THE PLAN SHALL DO SO BY CONTRACT WITH THE DEPARTMENT AND SHALL PROVIDE THE HEALTH CARE SERVICES COVERED BY THE PLAN TO EACH ENROLLEE.

(2) MANAGED CARE PLANS PARTICIPATING IN THE PLAN SHALL NOT DISCRIMINATE AGAINST ANY POTENTIAL OR CURRENT ENROLLEE BASED UPON HEALTH STATUS, SEX, RACE, ETHNICITY, OR RELIGION.

(3) MANAGED CARE PLANS THAT CONTRACT WITH THE DEPARTMENT TO PROVIDE THE PLAN TO ENROLLEES SHALL ALSO BE WILLING TO CONTRACT WITH THE MEDICAID MANAGED CARE PROGRAM, AS ADMINISTERED BY THE DEPARTMENT.

(4) THE DEPARTMENT MAY RECEIVE **AND** ACT **UPON** COMPLAINTS FROM ENROLLEES REGARDING FAILURE TO PROVIDE COVERED SERVICES OR EFFORTS TO OBTAIN PAYMENT, OTHER THAN AUTHORIZED COPAYMENTS, FOR COVERED SERVICES DIRECTLY FROM ELIGIBLE RECIPIENTS.

(5) PARENTS OR GUARDIANS OF CHILDREN SHALL CHOOSE A PARTICIPATING HEALTH MAINTENANCE ORGANIZATION BEFORE ENROLLING IN THE PLAN IN AREAS OF THE STATE WHERE A PARTICIPATING HEALTH MAINTENANCE ORGANIZATION **IS** AVAILABLE. THE DEPARTMENT WILL ASSIGN CHILDREN WHO **ARE** CURRENTLY ENROLLED IN THE PLAN AND WHOSE PARENTS OR GUARDIANS HAVE NOT SELECTED A HEALTH MAINTENANCE ORGANIZATION WITHIN A TIME PERIOD DETERMINED BY THE DEPARTMENT TO **A** PARTICIPATING HEALTH MAINTENANCE ORGANIZATION **WITH** THE CHILD'S PRIMARY CARE PHYSICIAN IN THE NETWORK. THE DEPARTMENT SHALL SEEK TO MAINTAIN CONTINUITY OF THE HEALTH PLAN BETWEEN MEDICAID AND THE CHILDREN'S BASIC HEALTH PLAN.

(6) THE DEPARTMENT SHALL ALLOW, AT LEAST ANNUALLY, AN OPPORTUNITY FOR ENROLLEES TO TRANSFER AMONG PARTICIPATING MANAGED CARE PLANS SERVING THEIR RESPECTIVE GEOGRAPHIC REGIONS. THE DEPARTMENT SHALL ESTABLISH A PERIOD OF AT LEAST TWENTY DAYS ANNUALLY **WHEN** THIS OPPORTUNITY IS AFFORDED ELIGIBLE RECIPIENTS. IN

GEOGRAPHIC REGIONS SERVED BY MORE THAN ONE PARTICIPATING MANAGED CARE PLAN, THE DEPARTMENT SHALL ENDEAVOR TO ESTABLISH A UNIFORM PERIOD FOR SUCH OPPORTUNITY.

(7) THE DEPARTMENT SHALL MAKE A PREMIUM RATE PAYMENT TO MANAGED CARE PLANS BASED **UPON** A DEFINED SCOPE OF SERVICES. THE DEPARTMENT SHALL ONLY USE MARKET RATE BIDS THAT DO NOT DISCRIMINATE AND ARE ADEQUATE TO ASSURE QUALITY, NETWORK SUFFICIENCY, AND LONG-TERM COMPETITIVENESS IN THE CHILDREN'S BASIC HEALTH PLAN MANAGED CARE MARKET. THE DEPARTMENT SHALL **RETAIN** A QUALIFIED ACTUARY TO ESTABLISH A LOWER LIMIT FOR SUCH BIDS. A CERTIFICATION BY SUCH ACTUARY TO THE APPROPRIATE LOWER LIMIT SHALL BE CONCLUSIVE EVIDENCE OF THE DEPARTMENT'S COMPLIANCE WITH THE REQUIREMENTS OF THIS SUBSECTION **(7)**. FOR THE PURPOSES OF **THIS** SUBSECTION (7), A "QUALIFIED ACTUARY" SHALL BE A PERSON DEEMED AS SUCH UNDER REGULATIONS PROMULGATED BY THE COMMISSIONER OF INSURANCE.

(8) **ALL** MANAGED CARE PLANS PARTICIPATING IN THE PLAN SHALL MEET STANDARDS REGARDING THE QUALITY OF SERVICES TO BE PROVIDED, **FINANCIAL** INTEGRITY, **AND** RESPONSIVENESS TO THE UNMET HEALTH CARE NEEDS OF CHILDREN THAT MAY BE SERVED.

**26-19-111. Department - privatization.** (1) THE GENERAL ASSEMBLY FINDS THAT THE CHILDREN'S BASIC HEALTH PLAN **IS** A PROGRAM UNDER WHICH THE PRIVATE SECTOR HAS A GREAT DEAL OF EXPERIENCE IN MAKING VARIOUS HEALTH CARE PLANS AVAILABLE TO THE PRIVATE SECTOR AND SERVING AS THE LIAISON BETWEEN LARGE EMPLOYERS AND HEALTH CARE PROVIDERS, INCLUDING BUT NOT LIMITED TO HEALTH MAINTENANCE ORGANIZATIONS. THE GENERAL ASSEMBLY THEREFORE DETERMINES THAT THE CHILDREN'S BASIC HEALTH PLAN INVOLVES DUTIES SIMILAR TO DUTIES CURRENTLY OR PREVIOUSLY PERFORMED BY STATE EMPLOYEES BUT IS DIFFERENT IN SCOPE AND POLICY OBJECTIVES FROM THE STATE MEDICAL ASSISTANCE PROGRAM.

(2) PURSUANT TO SECTION 24-50-504 (2) (a), C.R.S., THE DEPARTMENT SHALL ENTER INTO PERSONAL SERVICES CONTRACTS THAT CREATE AN INDEPENDENT CONTRACTOR RELATIONSHIP FOR THE ADMINISTRATION OF THE CHILDREN'S BASIC HEALTH PLAN, INCLUDING OUTREACH, MARKETING, ELIGIBILITY DETERMINATION, AND ENROLLMENT. THE DEPARTMENT MAY ENTER INTO ADDITIONAL PERSONAL SERVICES

CONTRACTS FOR OTHER ADMINISTRATIVE FUNCTIONS REQUIRED BY THIS ARTICLE.

(3) THE IMPLEMENTATION OF **THIS** SECTION IS CONTINGENT UPON A **FINDING** BY THE STATE PERSONNEL DIRECTOR THAT ANY OF THE CONDITIONS OF SECTION 24-50-504 (2), C.R.S., HAVE BEEN MET OR THAT THE CONDITIONS OF SECTION 24-50-503 (1), C.R.S., HAVE BEEN MET.

**26-19-112. Authority to the department to apply for federal waivers.** THE DEPARTMENT IS HEREBY AUTHORIZED AND REQUIRED TO APPLY FOR ANY FEDERAL WAIVERS NECESSARY TO IMPLEMENT THE PURPOSES OF THIS ARTICLE.

**SECTION 2.** 26-17-103 (5), Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended to read:

**26-17-103. Definitions.** As used in this article, unless the context otherwise requires:

(5) "Eligible persons" means children who are less than ~~thirteen~~ EIGHTEEN years of age, who are eligible under the medically indigent program established in article 15 of this title or are eligible under one of the programs specified in section 26-17-107.5, who are not eligible for medical assistance under the medical assistance program pursuant to article 4 of this title, and who are not otherwise insured for the covered services.

**SECTION 3.** 26-17-105 (2), Colorado Revised Statutes, 1989 Repl. Vol., as amended, is repealed as follows:

**26-17-105. Powers and duties of administrator.** (2) ~~The board shall divide the state into regions based upon the number of eligible persons and the number of provider resources. The administrator may select a region of the state for the initial operation of the plan, taking into account the levels and rates of unemployment in different areas of the state, the unmet need for basic health care services to a population reasonably representative of the portion of the state's population that lacks such coverage, and the need for geographic, demographic, and economic diversity. Any expansion of the program to additional regions of the state in subsequent years shall be subject to approval by the general assembly.~~

**SECTION 4.** Appropriation - adjustment in 1997 Long Bill.

(1) In addition to any other appropriation for the fiscal year beginning July 1, 1996, there is hereby appropriated, out of any moneys in the general fund not otherwise appropriated, to the children's basic health plan trust created in section 26-19-105, Colorado Revised Statutes, the **sum** of two million dollars (\$2,000,000).

(2) In addition to any other appropriation for the fiscal year beginning July 1, 1997, there is hereby appropriated, to the department of health care policy and financing, medical programs, other medical programs, out of any moneys in the children's basic health plan trust fund, the **sum** of two million dollars (\$2,000,000), or so much thereof as may be necessary for the implementation of this act.

(3) For the implementation of this act, a lettered note designation made in the annual general appropriation act shall be modified as follows: The lettered note associated with the department of higher education, regents of the university of Colorado health sciences center, Colorado child health plan shall be modified to show that the **sum** of two million three hundred seventy-four thousand five hundred seventy dollars (\$2,374,570) shall be **from** program reserves and from moneys received from the department of health care policy and financing.

**SECTION 5. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.**

~~Charles E. Berry~~  
**SPEAKER OF THE HOUSE  
OF REPRESENTATIVES**

**Tom Norton  
PRESIDENT OF  
THE SENATE**

~~Madith M. Rodrigue~~  
**CHIEF CLERK OF THE HOUSE  
OF REPRESENTATIVES**

**Joan M. Albi  
SECRETARY OF  
THE SENATE**

**APPROVED**

~~Roy Kohn~~  
**GOVERNOR OF THE STATE OF COLORADO**

# An Act

SENATE BILL 97-005

BY SENATORS Hopper, Bishop, Hernandez, Johnson, Matsunaka, Norton, Reeves, Rizzuto, Weddig, and Wham;  
also REPRESENTATIVES Owen, Clarke, Dyer, Grampsas, Hagedorn, Keller, Lawrence, Leyba, and Saliman.

CONCERNING MEDICAID MANAGED CARE, AND MAKING AN APPROPRIATION  
IN CONNECTION THEREWITH.

*Be it enacted by the General Assembly of the State of Colorado:*

**SECTION 1.** Part 1 of article 4 of title 26, Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW SECTION to read:

**26-4-101.5. Short title - citation.** THIS SUBPART 1 CONSISTS OF SECTIONS 26-4-101 TO 26-4-110 AND **MAY** BE CITED AS SUBPART 1. THE TITLE OF THIS SUBPART 1 SHALL BE KNOWN AND **MAY** BE **CITED AS** "GENERAL PROVISIONS".

**SECTION 2.** 26-4-104, Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended to read:

**26-4-104.** Program of **medical assistance - single state agency.**

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Capital letters indicate new material added to existing statutes; dashes ~~through~~ words indicate deletions from existing statutes and such material not part of act.

~~(1)~~ The state department, by rules and regulations, shall establish a program of medical assistance to provide necessary medical care for the categorically ~~needy~~. The state department is hereby designated as the single state agency to administer such program in accordance with Title XIX and this article. Such program shall not be required to furnish recipients under sixty-five years of age the benefits that are provided to recipients sixty-five years of age and over under Title XVIII of the social security act; but said program shall otherwise be uniform to the extent required by Title XIX of the social security act.

~~(2) The state department shall promulgate rules and regulations which establish a managed care system for the provision of medical services under this article. Said rules may include, but are not limited to, the establishment of programs which require the selection of one physician or organization to provide primary care and consultation to a recipient of assistance under this article, standards for selection of a primary care provider, utilization review and quality assurance programs, and financial incentives for the operation of a program.~~

SECTION 3. Part 1 of article 4 of title 26, Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW SUBPART CONTAINING RELOCATED PROVISIONS, WITH AMENDMENTS, to read:

#### SUBPART 2 STATEWIDE MANAGED CARE SYSTEM

**26-4-111.** Short title - citation. THIS SUBPART 2 CONSISTS OF SECTIONS **26-4-111** TO **26-4-130** AND MAY BE CITED AS SUBPART 2. THE TITLE OF THIS SUBPART 2 SHALL BE KNOWN AND MAY BE CITED AS THE "STATEWIDE MANAGED CARE SYSTEM".

**26-4-112.** Legislative declaration. (1) ~~THE~~ GENERAL ASSEMBLY HEREBY FINDS THAT:

(a) COLORADO'S BUDGET, LIKE THE BUDGETS OF MANY STATES, HAS BEEN CONSTRAINED BY THE INCREASING COSTS ASSOCIATED WITH FEDERAL PROGRAMS. FEDERAL MANDATES CAUSE STATE BUDGETARY STRAIN WHEN IMPOSED **WITHOUT** CORRESPONDING ADJUSTMENTS TO THE FINANCING FORMULA FOR DETERMINING THE FEDERAL-STATE SHARE. THIS PHENOMENON HAS BEEN PARTICULARLY EVIDENT IN THE IMPLEMENTATION OF THE FEDERAL MEDICAID PROGRAM.

(b) THE FEDERAL MEDICAID PROGRAM DOES NOT ADEQUATELY ADDRESS ~~THE~~ NEEDS OF ALL IMPOVERISHED COLORADO CITIZENS AND, AS A RESULT, THIS STATE FINDS IT NECESSARY TO ADDRESS THE MEDICAL NEEDS OF ITS POOR THROUGH STATE-FUNDED PROGRAMS, INCLUDING BUT NOT LIMITED TO THE "CHILDREN'S HEALTH PLAN ACT", ARTICLE 17 OF THIS TITLE, AND THE "REFORM ACT FOR THE PROVISION OF HEALTH CARE FOR THE MEDICALLY INDIGENT", ARTICLE 15 OF THIS TITLE;

(c) (I) THE FEDERAL GOVERNMENT MAY CHOOSE TO PROVIDE FUNDING FOR MEDICAL ASSISTANCE PROGRAMS THROUGH FEDERAL BLOCK GRANTS. IF STATES ARE GIVEN MAXIMUM FLEXIBILITY FOR THE IMPLEMENTATION OF MEDICAL ASSISTANCE PROGRAMS USING THE BLOCK GRANTS, ~~THIS~~ STATE MAY BE IN A POSITION TO BALANCE THE STATE'S TOTAL BUDGETARY NEEDS WITH ~~THE~~ NEEDS OF THE STATE'S POOR WITHOUT ADHERENCE TO RESTRICTIVE FEDERAL REQUIREMENTS THAT MAY BE IMPRACTICAL FOR COLORADO.

(II) IF THE FEDERAL GOVERNMENT REDUCES ITS FEDERAL FINANCIAL PARTICIPATION WITHOUT MAKING ANY CORRESPONDING CHANGES TO FEDERAL REQUIREMENTS, ~~THIS~~ STATE WILL NEED ~~TO~~ DETERMINE WHICH POPULATIONS CAN BE SERVED IN THE MOST COST-EFFICIENT MANNER;

(d) WHETHER THE FEDERAL GOVERNMENT FUNDS MEDICAL ASSISTANCE PROGRAMS THROUGH BLOCK GRANTS OR REDUCES ~~ITS~~ FINANCIAL PARTICIPATION WITHOUT CHANGING ANY FEDERAL REQUIREMENTS, COLORADO HAS AN OPPORTUNITY TO ADOPT INNOVATIVE AND COST-EFFICIENT STATE MEDICAL ASSISTANCE STRATEGIES FOR MEETING THE MEDICAL NEEDS OF ITS IMPOVERISHED CITIZENS;

(e) THE EXPERIENCE OF OTHER STATES INDICATES THAT REACTIVE, RAPID, AND COMPREHENSIVE CHANGES TO A STATE'S MEDICAL ASSISTANCE PROGRAM CAN BE COSTLY AND INEFFICIENT;

(f) COLORADO HAS ADOPTED MANAGED CARE ON A SMALL SCALE BASIS FOR SPECIFIC POPULATIONS AND ~~IS~~ CONDUCTING PILOT PROGRAMS FOR OTHER POPULATIONS, INCLUDING BUT NOT LIMITED TO MANAGED CARE, CAPITATED MANAGED CARE, THE USE OF PRIMARY CARE PHYSICIANS, COPAYMENTS, AND MANAGED CARE PROGRAMS FOR THE ELDERLY SUCH AS THE **PACE** PROGRAM;

(g) IT IS IN THE STATE'S BEST INTEREST TO ENSURE THAT ALL MEDICAL ASSISTANCE PROGRAMS PROMOTE INDEPENDENT LIVING AND THAT ALL REGULATIONS FOR SUCH PROGRAMS ARE DEVELOPED WITH MAXIMUM

RECIPIENT INVOLVEMENT; AND

**(h)** ~~TO THE EXTENT IT IS NECESSARY FOR THE STATE DEPARTMENT TO~~ ASSIGN A RECIPIENT TO A MANAGED CARE PROVIDER, THE STATE DEPARTMENT SHALL TO THE EXTENT POSSIBLE CONSIDER THE CONTINUUM OF THE RECIPIENT'S CARE.

**(2)** THE GENERAL ASSEMBLY FURTHER FINDS THAT, WITH RECOMMENDATIONS FROM THE MEDICAL ASSISTANCE REFORM ADVISORY COMMITTEE CREATED IN SECTION **26-4-704**, THE OFFICE OF STATE PLANNING AND BUDGETING HAS STUDIED THE ALTERNATIVE METHODS OF PROVIDING MEDICAL ASSISTANCE TAKING INTO ACCOUNT COST-EFFICIENCY, CONTINUED RECEIPT OF FEDERAL MONEYS, AND MINIMAL IMPACT ON THE QUALITY OF MEDICAL ASSISTANCE FOR POOR PERSONS IN THIS STATE.

**(3) (a)** ~~THE~~ GENERAL ASSEMBLY DECLARES THAT ~~IT IS IN~~ THE STATE'S BEST INTEREST TO USE SAVINGS IN MEDICAID PER CAPITA COSTS FROM THE IMPLEMENTATION OF THIS SUBPART **2** AND FROM THE IMPLEMENTATION OF SECTION **26-4-404 (1)** (b) TO COVER THE ADMINISTRATIVE COSTS OF IMPLEMENTING MANAGED CARE PURSUANT TO THE PROVISIONS OF THIS SUBPART **2**.

(b) REMAINING SAVINGS IN MEDICAID PER CAPITA COSTS FROM THE IMPLEMENTATION OF THIS SUBPART **2** SHALL BE USED TO ESTABLISH PROGRAMS TO ~~INSURE~~ ADDITIONAL LOW-INCOME COLORADANS AND TO SUPPORT ESSENTIAL COMMUNITY PROVIDERS AS LONG ~~AS~~ SUCH NEW PROGRAMS DO NOT CREATE AN ENTITLEMENT TO SERVICES AND MINIMIZE ANY SUBSTITUTION OF SUBSIDIZED COVERAGE FOR EMPLOYER-BASED COVERAGE.

(c) REMAINING SAVINGS IN MEDICAID PER CAPITA COSTS FROM THE IMPLEMENTATION OF SECTION **26-4-404 (1)** (b) MAY BE USED FOR ~~THE~~ EXPANSION OF THE INCENTIVE PROGRAM TO PROVIDERS OF DENTAL SERVICES FOR CHILDREN UNDER THE EARLY PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT PROGRAM.

**(4)** ~~THE~~ GENERAL ASSEMBLY ~~THEREFORE~~ DECLARES THAT IT IS IN THE STATE'S BEST INTEREST TO ADOPT THIS SUBPART **2**.

**26-4-113. Statewide managed care system - implementation required. (1) Rules. (a)** EXCEPT AS PROVIDED IN SUBSECTION **(5)** OF THIS SECTION, THE STATE DEPARTMENT SHALL ADOPT RULES TO IMPLEMENT A MANAGED CARE SYSTEM FOR SEVENTY-FIVE PERCENT OF THE COLORADO

MEDICAL-ASSISTANCE POPULATION ON A STATEWIDE BASIS PURSUANT TO THE PROVISIONS OF **THIS** ARTICLE. THE MANAGED CARE SYSTEM IMPLEMENTED PURSUANT TO THIS ARTICLE SHALL NOT INCLUDE THE SERVICES DELIVERED UNDER THE RESIDENTIAL CHILD HEALTH CARE PROGRAM DESCRIBED IN SECTION **26-4-527**. THE RULES SHALL INCLUDE A PLAN TO IMPLEMENT THE STATEWIDE MANAGED CARE SYSTEM OVER A THREE-YEAR PERIOD PURSUANT TO THE PROVISIONS OF SUBSECTION (2) **OF THIS** SECTION.

(b) IT IS THE GENERAL ASSEMBLY'S INTENT THAT THE STATE DEPARTMENT ELIMINATE ADMINISTRATIVE RULES AND FUNCTIONS THAT ARE UNNECESSARY AND UNRELATED TO THE IMPLEMENTATION **OF** THE STATEWIDE MANAGED CARE SYSTEM. THE RULES AND FUNCTIONS SHALL BE REDUCED ACCORDING TO **THE** SCHEDULE FOR IMPLEMENTING THE STATEWIDE MANAGED **CARE** SYSTEM IN SUBSECTION (2) OF THIS SECTION. THE STATE DEPARTMENT SHALL TAKE INTO CONSIDERATION RECOMMENDATIONS FROM MANAGED CARE PROVIDERS, RECIPIENTS OR THEIR ADVOCATES, HEALTH CARE COVERAGE COOPERATIVES, AND THE MEDICAL, ASSISTANCE **REFORM** ADVISORY COMMITTEE IN ELIMINATING UNNECESSARY AND UNRELATED RULES AND FUNCTIONS.

**(2) Statewide managed care - implementation.** (a) SUBJECT TO THE PROVISIONS **OF** SUBSECTION **(5)** **OF THIS** SECTION AND SECTION **26-4-121 (2)**, IF THE EXECUTIVE DIRECTOR DETERMINES THAT THEY HAVE BEEN EFFECTIVE, ALL MANAGED CARE CONTRACTS AND PILOT PROJECTS IN EFFECT OR WITH APPROVED FEDERAL WAIVERS AS OF JULY 1, 1997, MAY BE IMPLEMENTED ON A STATEWIDE BASIS NO LATER THAN JULY 1, 2000, UNLESS OTHERWISE REPEALED BY THE GENERAL ASSEMBLY BEFORE THAT DATE.

(b) MANAGED CARE PILOT PROJECTS THAT SHALL BE IN EFFECT OR AUTHORIZED AS OF JULY 1, 1997, **ARE** THE FOLLOWING:

(I) **Acute and long-term care.** THE INTEGRATED CARE AND FINANCING PROJECT TO STUDY THE INTEGRATION OF ACUTE AND LONG-TERM CARE, AS DESCRIBED IN SECTION **26-4-122**;

(II) **Managed care contracts.** **LIMITED** ENROLLMENT IN CAPITATED MANAGED CARE FOR MEDICAL ASSISTANCE RECIPIENTS.

(III) **Mental health.** MANAGED MENTAL HEALTH SERVICES, AS DESCRIBED IN SECTION **26-4-123** [FORMERLY **26-4-5281**];

(IV) **Elderly.** PROGRAM **OF** ALL-INCLUSIVE CARE **FOR** THE ELDERLY, AS DESCRIBED IN SECTION **26-4-124** [FORMERLY **26-4-519**];

(3) **Bidding.** THE STATE DEPARTMENT IS AUTHORIZED TO INSTITUTE A PROGRAM FOR COMPETITIVE BIDDING PURSUANT TO SECTION **24-103-202** OR **24-103-203, C.R.S.**, FOR PROVIDING MEDICAL SERVICES ON A MANAGED CARE BASIS FOR PERSONS ELIGIBLE TO BE ENROLLED IN MANAGED CARE. THE STATE DEPARTMENT IS AUTHORIZED TO AWARD CONTRACTS TO MORE THAN ONE ~~OFFEROR.~~ **THE** STATE DEPARTMENT PROCEDURES SHALL SEEK TO USE COMPETITIVE BIDDING PROCEDURES TO MAXIMIZE THE NUMBER OF MANAGED CARE CHOICES AVAILABLE TO MEDICAID CLIENTS OVER THE LONG TERM THAT MEET THE **REQUIREMENTS** OF SECTIONS **26-4-115** AND **26-4-117**.

(4) **Waivers.** THE IMPLEMENTATION OF THIS SUBPART **2** IS CONDITIONED, TO THE EXTENT APPLICABLE, ON THE ISSUANCE OF NECESSARY WAIVERS BY THE ~~FEDERAL~~ **GOVERNMENT.** ~~THE~~ PROVISIONS OF THIS SUBPART **2** SHALL BE IMPLEMENTED TO THE EXTENT AUTHORIZED BY FEDERAL WAIVER, IF SO REQUIRED BY FEDERAL LAW.

(5) **Long-term care assessment.** (a) WITH THE EXCEPTION OF THE PILOT PROGRAMS DESCRIBED IN SUBSECTION (2) OF ~~THIS~~ SECTION, THE STATE DEPARTMENT SHALL NOT CONTRACT FOR LONG-TERM CARE SERVICES AS PART OF THE STATEWIDE MANAGED CARE SYSTEM UNTIL FURTHER AUTHORIZATION BY THE JOINT BUDGET COMMITTEE, THE COMMITTEE ON HEALTH, ENVIRONMENT, WELFARE, AND INSTITUTIONS IN THE SENATE, AND THE COMMITTEE ON HEALTH, ENVIRONMENT, WELFARE, **AND** INSTITUTIONS IN THE HOUSE OF REPRESENTATIVES FOLLOWING THE STATE DEPARTMENT'S ASSESSMENT REQUIRED BY PARAGRAPH (b) OF THIS SUBSECTION (5). FOR PURPOSES OF THIS SUBSECTION (5), "LONGTERM CARE SERVICES" MEANS NURSING FACILITY AND HOME AND COMMUNITY-BASED SERVICES PROVIDED TO ELIGIBLE RECIPIENTS WHO HAVE BEEN DETERMINED TO BE IN NEED OF SUCH SERVICES BY A SINGLE ENTRY POINT AGENCY OR PROFESSIONAL REVIEW ORGANIZATION AS REQUIRED BY TITLE **XIX** OF THE SOCIAL SECURITY ACT.

(b) DURING THE THREE-YEAR PERIOD FOR IMPLEMENTATION OF STATEWIDE MANAGED CARE PURSUANT TO SUBSECTION (2) OF THIS SECTION, THE STATE DEPARTMENT SHALL ASSESS THE RESULTS OF THE INTEGRATED CARE AND FINANCING PROJECT DESCRIBED IN SECTION **26-4-122**, THE PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY DESCRIBED IN SECTION **26-4-124**, AND, IF SENATE BILL 97-42 BECOMES LAW, THE SYSTEM OF CASE-MIX REIMBURSEMENT FOR NURSING FACILITIES, INCLUDING PAYMENT FOR ANCILLARY SERVICES SUCH AS PHARMACEUTICAL SERVICES, PRESCRIPTION DRUGS, AND OXYGEN AS PART OF THAT SYSTEM. THE STATE DEPARTMENT'S ASSESSMENT SHALL INCLUDE CONSIDERATION OF COMMENTS AND INPUT FROM LONG-TERM CARE PROVIDERS, RECIPIENTS OR THEIR

ADVOCATES, AND FAMILIES. **THE** STATE DEPARTMENT SHALL INCLUDE IN ITS ANNUAL REPORT REQUIRED PURSUANT TO SECTION 26-4-118 A SUMMARY OF ITS ONGOING ANALYSIS OF **THE** RESULTS OF THESE PROGRAMS AND SYSTEMS.

**(6) Graduate medical education.** (a) THE GENERAL ASSEMBLY DECLARES THAT GRADUATE MEDICAL EDUCATION, REFERRED TO IN THIS SUBSECTION (6) AS "GME" IS OF VALUE TO THE STATE AND THE PEOPLE OF COLORADO. **THE** GENERAL ASSEMBLY RECOGNIZES THAT MEDICAID MONIES HAVE HISTORICALLY CONTRIBUTED TO THE FUNDING OF GME BY BEING INCLUDED IN THE **RATE** PAID TO TEACHING HOSPITALS UNDER THE MEDICAID FEE-FOR-SERVICE PROGRAM. THE GENERAL ASSEMBLY INTENDS THAT FISCAL SUPPORT FOR GME CONTINUE, BUT FINDS THAT UNDER A MANAGED CARE ENVIRONMENT, MCO'S WOULD HAVE NO OBLIGATION OR INCENTIVE TO CONTINUE THIS SUPPORT FOR GME.

(b) THE STATE DEPARTMENT SHALL CONTINUE THE GME FUNDING TO TEACHING HOSPITALS THAT HAVE GRADUATE MEDICAL EDUCATION EXPENSES IN THEIR MEDICARE COST REPORT AND ARE PARTICIPATING AS PROVIDERS UNDER ONE OR MORE MCO WITH A CONTRACT WITH THE STATE DEPARTMENT UNDER THIS SUBPART 2. GME FUNDING FOR RECIPIENTS ENROLLED IN AN MCO SHALL BE EXCLUDED FROM THE PREMIUMS PAID TO THE MCO **AND** SHALL BE PAID DIRECTLY TO THE TEACHING HOSPITAL. THE MEDICAL SERVICES BOARD SHALL ADOPT RULES TO IMPLEMENT THIS SUBSECTION (6) AND ESTABLISH THE RATE AND METHOD OF REIMBURSEMENT.

(c) THIS SUBSECTION (6) SHALL BE IMPLEMENTED AS SOON AS PRACTICAL, BUT NOT LATER THAN JANUARY 1, 1998.

**(7) Annual savings report and use of savings.** (a) BY SEPTEMBER 1 OF EACH YEAR, THE STATE DEPARTMENT SHALL SUBMIT TO THE JOINT BUDGET COMMITTEE, THE HEALTH, ENVIRONMENT, WELFARE, AND INSTITUTIONS COMMITTEE OF THE SENATE, THE HEALTH, ENVIRONMENT, WELFARE, AND INSTITUTIONS COMMITTEE OF THE HOUSE OF REPRESENTATIVES, AND TO THE OFFICE OF STATE PLANNING AND BUDGETING A SAVINGS REPORT STATING THE COST SAVINGS REALIZED OR ANTICIPATED IN THE PREVIOUS, CURRENT, AND SUBSEQUENT STATE FISCAL YEARS FROM ENROLLMENT OF RECIPIENTS IN MANAGED CARE PROGRAMS PURSUANT TO THE PROVISIONS OF THIS SUBPART 2. THE REPORT SHALL INCLUDE AN ASSESSMENT OF THE EXTENT TO WHICH THE PROGRAM DESCRIBED IN SUBSECTION (8) OF THIS SECTION HAS REDUCED PROVIDERS' UNCOMPENSATED BURDENS AND AN ASSESSMENT OF CHANGES ON THE FINANCIAL VIABILITY OF ESSENTIAL COMMUNITY PROVIDERS. THE REPORT

SHALL ALSO INCLUDE A RECOMMENDATION FOR PRIORITIZING BETWEEN THE SUBSIDIZED INSURANCE PROGRAM DESCRIBED IN SUBSECTION (8) OF THIS SECTION AND THE GRANTS PROGRAMS DESCRIBED IN SUBSECTION (9) OF THIS SECTION, AND FOR PRIORITIZING RESOURCES WITHIN EACH OF THOSE PROGRAMS TO DIFFERENT POPULATIONS **AND** REGIONS OF THE STATE. THESE RECOMMENDATIONS SHALL BE BASED UPON QUANTITATIVE AND QUALITATIVE ASSESSMENTS OF NEEDS AND ON THE RELATIVE COST-EFFECTIVENESS OF DIFFERENT RESOURCE ALLOCATIONS.

(b) IN CALCULATING COST SAVINGS FROM ENROLLMENT OF RECIPIENTS IN MANAGED CARE PROGRAMS, THE STATE DEPARTMENT SHALL CALCULATE THE TOTAL ANNUAL COST SAVINGS FROM GROWTH IN MANAGED CARE ENROLLMENT SUBSEQUENT TO JULY **1, 1997, AND** TOTAL ANNUAL COST SAVINGS FROM ACTUAL REDUCTIONS IN ADMINISTRATIVE AND PROGRAMMATIC COSTS ASSOCIATED WITH THE IMPLEMENTATION OF THIS SUBPART 2. COST SAVINGS FOR EACH ADDITIONAL ENROLLEE SHALL BE CALCULATED AS THE DIFFERENCE IN PER CAPITA COST BETWEEN AN ENROLLEE IN FEE-FOR-SERVICE MEDICAID AND A SIMILAR ENROLLEE IN MANAGED CARE.

(c) THE GENERAL ASSEMBLY SHALL ANNUALLY APPROPRIATE ALL SAVINGS ACHIEVED THROUGH IMPLEMENTATION OF THIS SUBPART 2 AND DESCRIBED IN THIS SUBSECTION (7) TO COVER THE ADMINISTRATIVE COSTS OF IMPLEMENTING MANAGED CARE PURSUANT TO THE PROVISIONS OF THIS SUBPART 2 AND THE COSTS OF PROGRAMS PROVIDED IN **SUBSECTIONS (8) AND (9)** OF THIS SECTION AND ANY OTHER COST-EFFECTIVE OPTIONS TO EXPAND ACCESS TO SERVICES FOR THE MEDICALLY INDIGENT POPULATION. IT IS THE INTENT OF THE GENERAL ASSEMBLY THAT THE MANDATORY AND OPTIONAL POPULATIONS AND BENEFITS PROVIDED BY THE "COLORADO MEDICAL ASSISTANCE ACT" AS OF JUNE 30, **1997, ARE** A HIGHER PRIORITY FOR FUNDING THAN THE WAIVERED OPTIONAL PROGRAMS DESCRIBED IN SUBSECTIONS (8) AND (9) OF THIS SECTION. SUCH APPROPRIATIONS SHALL INCLUDE ALL ANTICIPATED COST SAVINGS SUBSEQUENT TO JULY **1, 1997, THAT ARE** ACHIEVED THROUGH THE IMPLEMENTATION OF THIS SUBPART 2 **AND** DESCRIBED IN **THIS** SUBSECTION (7). BEGINNING **WITH** AND SUBSEQUENT TO STATE FISCAL YEAR **1999-2000**, SUCH APPROPRIATIONS SHALL INCLUDE ALL OF THE SAVINGS DESCRIBED IN THE ANNUAL SAVINGS REPORT DESCRIBED IN PARAGRAPH (a) OF **THIS** SUBSECTION (7).

(d) THE STATE DEPARTMENT SHALL MONITOR ACTUAL MANAGED **CARE** SAVINGS REALIZED **DURING A** PARTICULAR FISCAL YEAR BASED UPON THE METHODOLOGY DESCRIBED IN PARAGRAPH (b) OF THIS SUBSECTION (7). TO THE EXTENT THAT THE GENERAL ASSEMBLY HAS APPROPRIATED

MANAGED CARE SAVINGS PURSUANT TO PARAGRAPH (c) OF THIS SUBSECTION (7) AND THE STATE DEPARTMENT DETERMINES THAT IT WILL NOT REALIZE ALL OF SUCH MANAGED CARE SAVINGS DURING A PARTICULAR FISCAL YEAR, THE STATE DEPARTMENT SHALL RESTRICT ITS SPENDING UNDER SUBSECTIONS (8) AND (9) OF THIS SECTION.

(e) TO IMPLEMENT THE PROVISIONS OF PARAGRAPH (d) OF THIS SUBSECTION (7), THE STATE DEPARTMENT SHALL SUBMIT SUPPLEMENTAL APPROPRIATION REQUESTS DURING A PARTICULAR FISCAL YEAR TO MODIFY APPROPRIATIONS FOR THE PROGRAMS DESCRIBED IN SUBSECTIONS (8) AND (9) OF THIS SECTION.

(f) THE STATE DEPARTMENT SHALL NOT SPEND MONEYS FROM MANAGED CARE SAVINGS ON ~~THE~~ PROGRAMS DESCRIBED IN SUBSECTIONS (8) AND (9) OF ~~THIS~~ SECTION DURING THE FISCAL YEAR BEGINNING JULY 1, 1997.

**(8) Subsidized insurance coverage.** (a) THERE IS HEREBY CREATED A SUBSIDIZED INSURANCE PROGRAM, REFERRED TO IN THIS SUBSECTION (8) AS THE "PROGRAM", THAT SHALL PROVIDE SUBSIDIZED INSURANCE COVERAGE FOR UNINSURED CHILDREN UNDER AGE NINETEEN. SUCH PROGRAM SHALL BE LIMITED TO PERSONS WITH FAMILIES WITH INCOMES LESS THAN OR EQUAL TO ONE HUNDRED EIGHTY-FIVE PERCENT OF THE FEDERAL POVERTY LEVEL. ~~THE~~ STATE DEPARTMENT IS HEREBY AUTHORIZED TO SEEK THE NECESSARY FEDERAL WAIVERS TO IMPLEMENT THE PROGRAM.

(b) NOTHING IN ~~THIS~~ SUBSECTION (8) OR ANY RULES PROMULGATED PURSUANT TO THE PROGRAM SHALL BE INTERPRETED TO CREATE A LEGAL ENTITLEMENT IN ANY PERSON TO SUBSIDIZED INSURANCE COVERAGE.

(c) ENROLLMENT IN THE PROGRAM SHALL BE LIMITED BASED UPON ANNUAL APPROPRIATIONS BY THE GENERAL ASSEMBLY AS DESCRIBED IN PARAGRAPH (c) OF SUBSECTION (7) OF THIS SECTION. THE GENERAL ASSEMBLY SHALL ANNUALLY ESTABLISH MAXIMUM ENROLLMENT FIGURES FOR CHILDREN.

(d) TO BE ELIGIBLE FOR A SUBSIDY UNDER THE PROGRAM, A CHILD MUST NOT HAVE CURRENTLY NOR IN THE THREE MONTHS PRIOR TO APPLICATION FOR THE PROGRAM HAVE BEEN INSURED BY A COMPARABLE HEALTH PLAN THROUGH AN EMPLOYER, WITH THE EMPLOYER CONTRIBUTING AT LEAST FIFTY PERCENT OF THE PREMIUM COST; EXCEPT THAT A CHILD WHO HAS LOST INSURANCE COVERAGE DUE TO A CHANGE IN OR LOSS OF EMPLOYMENT SHALL NOT BE SUBJECT TO THE THREE-MONTH WAITING PERIOD.

(e) IN IMPLEMENTING THIS PROGRAM, THE STATE DEPARTMENT SHALL CONTRACT FOR MANAGED CARE SERVICES WITH THE **SAME** GOALS AND UNDER THE **SAME** CONDITIONS AS **THOSE** DESCRIBED IN THIS SUBPART 2 AND SHALL SEEK TO PRIVATIZE ADMINISTRATIVE FUNCTIONS IN THE SAME MANNER AS DESCRIBED IN SECTION **26-4-120**.

(f) THE STATE DEPARTMENT SHALL DEFINE BENEFITS FOR THIS PROGRAM BASED UPON THE STANDARD AND BASIC HEALTH BENEFITS PLANS DESCRIBED IN ARTICLE **16** OF TITLE **10**, C.R.S.

(g) THE STATE DEPARTMENT MAY REQUIRE ENROLLEES IN THE PROGRAM TO PAY A PORTION OF THE PREMIUM COSTS FOR THE PROGRAM AND PAY FOR A PORTION OF THE COST OF SERVICES DELIVERED UNDER THE PROGRAM. ON OR BEFORE JANUARY 1 OF EACH YEAR, THE STATE DEPARTMENT SHALL **SUBMIT** TO THE JOINT BUDGET COMMITTEE **ITS** PROPOSAL FOR A SCALE FOR INCREASING PREMIUMS OR SERVICE COST SHARING FOR THE PROGRAM BASED UPON A FAMILY'S INCOME.

(h) THE STATE DEPARTMENT SHALL ESTABLISH PROCEDURES FOR RECEIVING PART OR ALL OF THE REQUIRED PREMIUM PAYMENTS **UNDER** THE PROGRAM FROM OTHER HEALTH CARE PURCHASERS AND SHALL ESTABLISH PROCEDURES FOR BUYING HEALTH CARE INSURANCE WITH SUBSTANTIALLY **SIMILAR** BENEFITS TO THOSE UNDER **THE** PROGRAM THROUGH OTHER HEALTH CARE PURCHASERS.

(i) THE STATE DEPARTMENT MAY ESTABLISH RULES UNDER THE PROGRAM FOR DETERMINING ELIGIBILITY AND FOR ENROLLING ELIGIBLE PERSONS IN MANAGED CARE PLANS THAT ARE DIFFERENT **FROM** THE MEDICAL ASSISTANCE PROGRAM.

(j) **IN IMPLEMENTING** THE PROGRAM, THE STATE DEPARTMENT SHALL SEEK TO ACHIEVE A DISTRIBUTION OF ENROLLMENT IN THE PROGRAM BY COUNTY THAT IS AS SIMILAR AS POSSIBLE TO **THE** DISTRIBUTION OF ENROLLMENT IN CAPITATED MEDICAID MANAGED CARE PROGRAMS BY COUNTY.

(9) Grants programs. (a) SUBJECT TO APPROPRIATIONS AS DESCRIBED IN PARAGRAPH (c) OF SUBSECTION (7) OF THIS SECTION, THERE IS HEREBY CREATED A GRANT PROGRAM THAT SHALL BE ADMINISTERED BY THE STATE DEPARTMENT. THE PURPOSE OF THE GRANT PROGRAM **IS** TO ASSIST ESSENTIAL COMMUNITY PROVIDERS TO SERVE THE MEDICALLY INDIGENT POPULATION AND TO IDENTIFY AND IMPLEMENT ADDITIONAL COST-EFFECTIVE OPTIONS TO EXPAND ACCESS TO SERVICES FOR SAID

POPULATION.

(b) THE STATE DEPARTMENT SHALL PROMULGATE RULES FOR THE IMPLEMENTATION OF THE GRANT PROGRAM THAT SHALL INCLUDE BUT NOT BE LIMITED TO:

(I) PROCEDURES FOR APPLYING FOR A GRANT UNDER THIS SECTION;

(II) METHODS FOR THE EVALUATION OF APPLICATIONS FOR GRANTS UNDER THIS SECTION AND AWARD OF GRANTS UNDER THIS SUBSECTION (9); AND

(III) METHODS FOR EVALUATING THE GRANT PROGRAM.

(10) (a) BY NOVEMBER 1, 1997, THE STATE DEPARTMENT SHALL SUBMIT TO THE JOINT BUDGET COMMITTEE, THE HEALTH, ENVIRONMENT, WELFARE, AND INSTITUTIONS COMMITTEE OF THE SENATE, AND THE HEALTH, ENVIRONMENT, WELFARE, AND INSTITUTIONS COMMITTEE OF THE HOUSE OF REPRESENTATIVES A REPORT ON A PLAN TO DEVELOP A DENTAL SERVICES PROGRAM THAT ASSURES ACCESS TO DENTAL SERVICES FOR CHILDREN IN THE MEDICAID PROGRAM. ANY DENTAL RATE INCREASE MAY BE EFFECTIVE ON OR AFTER JULY 1, 1998.

(b) THIS SUBSECTION (10) IS REPEALED, EFFECTIVE JULY 1, 1998.

**26-4-114. Managed care organizations - definitions.**

(1) (a) **Managed care.** AS USED IN THIS SUBPART 2, "MANAGED CARE" MEANS:

(I) THE DELIVERY BY A MANAGED CARE ORGANIZATION, AS DEFINED IN SUBSECTION (2) OF THIS SECTION, OF A PREDEFINED SET OF SERVICES TO RECIPIENTS; OR

(II) THE DELIVERY OF SERVICES PROVIDED BY THE PRIMARY CARE PHYSICIAN PROGRAM ESTABLISHED IN SECTION 26-4-118.

(b) NOTHING IN THIS SECTION SHALL BE DEEMED TO AFFECT THE BENEFITS AUTHORIZED FOR RECIPIENTS OF THE STATE MEDICAL ASSISTANCE PROGRAM.

(2) **Managed care organization.** AS USED IN THIS SUBPART 2, "MANAGED CARE ORGANIZATION" MEANS AN ENTITY CONTRACTING WITH THE STATE DEPARTMENT THAT PROVIDES, DELIVERS, ARRANGES FOR, PAYS

FOR, OR REIMBURSES ANY OF THE COSTS OF HEALTH CARE SERVICES THROUGH THE RECIPIENT'S USE OF HEALTH CARE PROVIDERS MANAGED BY, OWNED BY, UNDER CONTRACT WITH, OR EMPLOYED BY THE ENTITY BECAUSE ~~THE ENTITY~~ OR THE STATE DEPARTMENT EITHER REQUIRES THE RECIPIENT'S USE OF THOSE PROVIDERS OR CREATES INCENTIVES, INCLUDING FINANCIAL INCENTIVES, FOR THE RECIPIENT'S USE OF THOSE PROVIDERS.

**(3) Essential community provider.** "ESSENTIAL COMMUNITY PROVIDER" OR "ECP" MEANS A HEALTH CARE PROVIDER THAT:

**(a)** HAS HISTORICALLY SERVED MEDICALLY NEEDY OR MEDICALLY INDIGENT PATIENTS AND DEMONSTRATES A COMMITMENT TO SERVE LOW-INCOME AND MEDICALLY INDIGENT POPULATIONS WHO MAKE UP A SIGNIFICANT PORTION OF ITS PATIENT POPULATION OR, IN THE CASE OF A SOLE COMMUNITY PROVIDER, SERVES THE MEDICALLY INDIGENT PATIENTS WITHIN ITS MEDICAL CAPABILITY; AND

**(b)** WAIVES CHARGES OR CHARGES FOR SERVICES ON A SLIDING SCALE BASED ON INCOME AND DOES NOT RESTRICT ACCESS OR SERVICES BECAUSE OF A CLIENT'S FINANCIAL LIMITATIONS.

**26-4-115. Selection of managed care organizations.** (1) THE MEDICAL SERVICES BOARD AFTER PUBLIC HEARING AND INPUT FROM ~~RECIPIENTS, THEIR~~ ADVOCATES, ~~AND~~ PROVIDERS SHALL ESTABLISH CRITERIA FOR THE SELECTION OF RISK-ASSUMING MCOS.

**(2)** MCO'S SHALL BE SELECTED BY THE STATE DEPARTMENT TO PARTICIPATE IN THE STATEWIDE MANAGED CARE SYSTEM BASED UPON THE MCO'S ASSURANCE AND THE STATE DEPARTMENT'S VERIFICATION OF COMPLIANCE WITH SPECIFIC CRITERIA SET BY THE MEDICAL SERVICES BOARD PURSUANT ~~TO THIS~~ SUBSECTION **(2)** THAT INCLUDE ~~BUT~~ ARE NOT LIMITED TO THE FOLLOWING:

**(a)** THE MCO WILL NOT INTERFERE WITH APPROPRIATE MEDICAL CARE DECISIONS RENDERED BY THE PROVIDER NOR PENALIZE THE PROVIDER FOR REQUESTING MEDICAL SERVICES OUTSIDE THE STANDARD TREATMENT PROTOCOLS DEVELOPED BY THE MCO OR ITS CONTRACTORS;

**(b)** THE MCO WILL MAKE OR ASSURE PAYMENTS TO PROVIDERS WITHIN THE TIME ALLOWED FOR THE STATE TO MAKE PAYMENTS ON STATE LIABILITIES UNDER THE RULES ADOPTED BY THE DEPARTMENT OF PERSONNEL PURSUANT TO SECTION **24-30-202** (13), C.R.S.;

(c) **AN** EDUCATIONAL COMPONENT IN THE MCO'S PLAN THAT TAKES **INTO** CONSIDERATION RECIPIENT INPUT AND THAT INFORMS RECIPIENTS AS TO AVAILABILITY OF PLANS AND USE OF THE MEDICAL, SERVICES SYSTEM, APPROPRIATE **PREVENTIVE** HEALTH CARE PROCEDURES, SELF-CARE, AND APPROPRIATE HEALTH CARE UTILIZATION;

(d) MINIMUM BENEFIT REQUIREMENTS AS ESTABLISHED BY THE MEDICAL SERVICES BOARD;

(e) PROVISION OF NECESSARY AND APPROPRIATE SERVICES TO RECIPIENTS THAT SHALL INCLUDE BUT NOT BE LIMITED TO **THE** FOLLOWING:

(I) WITH RESPECT TO RECIPIENTS WHO *ARE* UNABLE TO MAKE DECISIONS FOR THEMSELVES, COLLABORATION BY THE MCO AND ALL RELEVANT PROVIDERS IN THE **MCO'S** NETWORK SERVING THE RECIPIENTS WITH THE DESIGNATED ADVOCATE OR FAMILY MEMBER IN ALL DECISION-MAKING INCLUDING ENROLLMENT AND DISENROLLMENT;

(II) DELIVERY OF SERVICES THAT ARE COVERED BENEFITS IN A MANNER THAT ACCOMMODATES OR IS COMPATIBLE WITH THE RECIPIENT'S ABILITY TO FULFILL DUTIES AND RESPONSIBILITIES IN WORK AND COMMUNITY ACTIVITIES.

(f) APPROPRIATE USE OF ANCILLARY HEALTH CARE PROVIDERS BY APPROPRIATE QUALIFIED HEALTH CARE PROFESSIONALS;

(g) DATA COLLECTION AND REPORTING REQUIREMENTS ESTABLISHED BY THE MEDICAL SERVICES **BOARD**;

(h) TO THE EXTENT PROVIDED BY LAW OR WAIVER, PROVISION OF RECIPIENT BENEFITS THAT THE MEDICAL SERVICES BOARD SHALL DEVELOP AND THE STATE DEPARTMENT SHALL IMPLEMENT IN PARTNERSHIP WITH LOCAL GOVERNMENT AND THE PRIVATE SECTOR, INCLUDING BUT NOT LIMITED TO:

(I) RECIPIENT OPTIONS TO RENT, PURCHASE, OR OWN DURABLE MEDICAL EQUIPMENT;

(II) RECOGNITION FOR IMPROVED HEALTH STATUS OUTCOMES; OR

(III) RECEIPT OF MEDICAL DISPOSABLE SUPPLIES WITHOUT CHARGE;

(i) UTILIZATION REQUIREMENTS ESTABLISHED BY THE STATE

DEPARTMENT;

(j) A FORM OR PROCESS FOR MEASURING GROUP AND INDIVIDUAL RECIPIENT HEALTH OUTCOMES, INCLUDING BUT NOT LIMITED TO THE USE OF TOOLS OR METHODS THAT IDENTIFY INCREASED HEALTH STATUS OR MAINTENANCE OF THE INDIVIDUAL'S HIGHEST LEVEL OF FUNCTIONING, DETERMINE THE DEGREE OF MEDICAL ACCESS, AND REVEAL RECIPIENT SATISFACTION **AND HABITS**. SUCH **TOOLS SHALL** INCLUDE THE USE OF CLIENT SURVEYS, ANECDOTAL INFORMATION, COMPLAINT AND GRIEVANCE DATA, AND DISENROLLMENT INFORMATION. THE MCO SHALL ANNUALLY SUBMIT A CARE MANAGEMENT REPORT TO THE STATE DEPARTMENT THAT DESCRIBES TECHNIQUES USED BY THE MCO TO PROVIDE MORE EFFICIENT USE OF HEALTH CARE SERVICES, BETTER HEALTH STATUS FOR POPULATIONS SERVED, AND BETTER HEALTH OUTCOMES FOR INDIVIDUALS.

(k) FINANCIAL STABILITY OF THE MCO;

(l) ASSURANCE THAT THE MCO HAS NOT PROVIDED TO A RECIPIENT ANY PREMIUMS OR OTHER INDUCEMENTS IN EXCHANGE FOR THE RECIPIENT SELECTING THE MCO FOR COVERAGE;

(m) A GRIEVANCE PROCEDURE PURSUANT TO THE PROVISIONS IN SECTION 26-4-117(1) (b) THAT ALLOWS FOR THE TIMELY RESOLUTION OF DISPUTES REGARDING THE QUALITY OF CARE, SERVICES TO BE PROVIDED, AND OTHER ISSUES RAISED BY THE RECIPIENT. MATTERS SHALL BE RESOLVED IN A MANNER CONSISTENT WITH THE MEDICAL NEEDS OF THE INDIVIDUAL RECIPIENT. PURSUANT TO SECTION 25.5-1-107, **C.R.S.** A RECIPIENT MAY SEEK AN **ADMINISTRATIVE** REVIEW OF AN ADVERSE DECISION MADE BY THE MCO.

(n) WITH RESPECT TO PREGNANT WOMEN AND INFANTS, THE FOLLOWING:

(I) ENROLLMENT OF PREGNANT WOMEN **WITHOUT** RESTRICTIONS AND INCLUDING AN ASSURANCE THAT THE HEALTH CARE PROVIDER SHALL PROVIDE TIMELY ACCESS TO INITIATION OF PRENATAL CARE IN ACCORDANCE WITH PRACTICE STANDARDS;

(II) COVERAGE WITHOUT RESTRICTIONS FOR NEWBORNS, INCLUDING SERVICES SUCH AS, BUT NOT LIMITED TO, PREVENTIVE CARE, SCREENING, AND WELL-BABY EXAMINATIONS DURING THE FIRST MONTH OF LIFE;

(III) THE IMPOSITION OF PERFORMANCE STANDARDS AND THE USE OF

QUALITY INDICATORS WITH RESPECT TO PERINATAL, PRENATAL, AND POSTPARTUM CARE FOR WOMEN AND BIRTHING AND NEONATAL CARE FOR INFANTS. THE STANDARDS AND INDICATORS SHALL BE BASED ON NATIONALLY APPROVED GUIDELINES.

(IV) FOLLOW-UP BASIC HEALTH **MAINTENANCE** SERVICES FOR WOMEN AND CHILDREN, INCLUDING IMMUNIZATIONS AND EARLY PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES FOR CHILDREN AND APPROPRIATE PREVENTIVE CARE SERVICES FOR WOMEN;

(o) **THE MCO** WILL ACCEPT ALL **ENROLLEES** REGARDLESS OF HEALTH STATUS CONSISTENT WITH THE PROVISIONS OF SECTION 26-4-118;

(p) DISCLOSURE REQUIREMENTS AS ESTABLISHED BY THE STATE DEPARTMENT AND MEDICAL SERVICES BOARD;

(q) PROVIDE A MECHANISM WHEREBY A PRESCRIBING PHYSICIAN CAN REQUEST TO OVERRIDE RESTRICTIONS TO OBTAIN MEDICALLY NECESSARY OFF-FORMULARY PRESCRIPTION DRUGS, SUPPLIES, EQUIPMENT, OR SERVICES FOR HIS OR HER PATIENT;

(r) MAINTENANCE OF A NETWORK OF PROVIDERS SUFFICIENT TO ASSURE THAT ALL SERVICES TO RECIPIENTS WILL BE ACCESSIBLE WITHOUT UNREASONABLE DELAY. THE STATE DEPARTMENT SHALL DEVELOP EXPLICIT CONTRACT STANDARDS, IN CONSULTATION WITH STAKEHOLDERS, TO ASSESS AND MONITOR THE MCO'S CRITERIA. SUFFICIENCY SHALL BE DETERMINED IN ACCORDANCE WITH THE REQUIREMENTS OF **THIS** PARAGRAPH (r) AND MAY BE ESTABLISHED BY REFERENCE TO ANY REASONABLE CRITERIA USED BY THE MCO INCLUDING BUT NOT LIMITED TO THE FOLLOWING:

(I) GEOGRAPHIC ACCESSIBILITY IN REGARD TO THE SPECIAL NEEDS OF RECIPIENTS;

(II) WAITING TIMES FOR APPOINTMENTS WITH PARTICIPATING PROVIDERS;

(III) HOURS OF OPERATION;

(IV) VOLUME OF TECHNOLOGICAL AND SPECIALTY SERVICES AVAILABLE TO SERVE THE NEEDS OF RECIPIENTS REQUIRING TECHNOLOGICALLY ADVANCED OR SPECIALTY CARE.

(s) (I) FOR THE DELIVERY OF PRESCRIPTION DRUG BENEFITS TO

RECIPIENTS ENROLLED IN ~~AN~~ **MCO** WHO ARE RESIDENTS OF A NURSING FACILITY, MCO'S SHALL USE PHARMACIES WITH A DEMONSTRATED CAPABILITY OF PROVIDING PRESCRIPTION DRUGS IN A MANNER CONSISTENT **WITH** THE NEEDS OF CLIENTS IN INSTITUTIONAL SETTINGS SUCH AS NURSING FACILITIES. IN CASES WHERE A NURSING FACILITY AND A PHARMACY HAVE A CONTRACT FOR A SINGLE PHARMACY DELIVERY SYSTEM FOR RESIDENTS OF THE NURSING FACILITY:

(A) **AN MCO** PROVIDING PRESCRIPTION DRUG BENEFITS FOR RESIDENTS OF THE NURSING FACILITY SHALL AGREE TO CONTRACT WITH THAT PHARMACY UNDER REASONABLE CONTRACT **TERMS**; AND

(B) **THE** PHARMACY SHALL AGREE TO CONTRACT WITH EACH **MCO** THAT PROVIDES PRESCRIPTION DRUG BENEFITS FOR RESIDENTS OF THE NURSING FACILITY UNDER REASONABLE CONTRACT **TERMS**.

(II) **ANY** DISPUTES CONCERNING PROVIDING PRESCRIPTION DRUG BENEFITS BETWEEN NURSING FACILITIES, PHARMACIES, AND **MCO'S** THAT CANNOT BE RESOLVED THROUGH GOOD FAITH NEGOTIATIONS **MAY** BE RESOLVED THROUGH A PARTY REQUESTING AN **INFORMAL** REVIEW BY THE STATE DEPARTMENT OR, IF REQUESTED, A HEARING THROUGH THE STATE DEPARTMENT'S AGGRIEVED PROVIDER APPEAL PROCEDURES **IN** ACCORDANCE WITH SECTION **25.5-1-107 (2), C.R.S.**

(III) **THE** MEDICAL SERVICES BOARD SHALL ADOPT RULES REQUIRING MCO'S TO CONTRACT **WITH** QUALIFIED PHARMACY PROVIDERS **IN** A MANNER PERMITTING A NURSING FACILITY TO CONTINUE TO COMPLY WITH FEDERAL MEDICAID REQUIREMENTS OF PARTICIPATION FOR NURSING FACILITIES. SUCH RULES SHALL DEFINE "QUALIFIED PHARMACY PROVIDERS" AND SHALL BE BASED UPON CONSULTATIONS WITH NURSING FACILITIES, **MCO's**, PHARMACIES, AND MEDICAID CLIENTS. **THE** STATE DEPARTMENT SHALL PROVIDE MCO'S WITH A LIST OF PHARMACIES THAT HAVE A CONTRACT WITH NURSING FACILITIES SERVING RECIPIENTS IN NURSING FACILITIES IN EACH COUNTY IN WHICH THE MCO IS CONTRACTING WITH THE STATE DEPARTMENT.

(3) (a) **THE** MCO SHALL SEEK PROPOSALS FROM EACH **ECP** IN A COUNTY IN WHICH THE MCO IS ENROLLING RECIPIENTS FOR THOSE SERVICES THAT THE MCO PROVIDES OR INTENDS TO PROVIDE AND THAT **AN ECP** PROVIDES OR **IS** CAPABLE OF PROVIDING. TO ASSIST MCO'S IN SEEKING PROPOSALS, **THE** STATE DEPARTMENT SHALL PROVIDE MCO'S WITH A LIST OF ECP'S IN EACH COUNTY. **THE** MCO SHALL CONSIDER **SUCH** PROPOSALS IN GOOD FAITH AND SHALL, WHEN DEEMED REASONABLE BY THE MCO BASED

ON THE NEEDS OF ITS ENROLLEES, CONTRACT WITH ECP's. EACH ECP SHALL BE WILLING TO NEGOTIATE ON REASONABLY EQUITABLE TERMS WITH EACH MCO. ECP's MAKING PROPOSALS UNDER THIS SUBSECTION (3) MUST BE ABLE TO MEET THE CONTRACTUAL REQUIREMENTS OF THE MCO. THE REQUIREMENTS OF THIS SUBSECTION (3) SHALL NOT APPLY TO AN MCO IN AREAS IN WHICH THE MCO OPERATES ENTIRELY AS A GROUP MODEL HEALTH MAINTENANCE ORGANIZATION.

(b) ANY DISPUTES BETWEEN AN MCO AND AN ECP THAT CANNOT BE RESOLVED THROUGH GOOD FAITH NEGOTIATIONS MAY BE RESOLVED THROUGH A PARTY REQUESTING AN INFORMAL REVIEW BY THE STATE DEPARTMENT, OR, IF REQUESTED, A HEARING THROUGH THE STATE DEPARTMENT'S AGGRIEVED PROVIDER APPEAL PROCESS IN ACCORDANCE WITH SECTION 25.5-1-107 (2), C.R.S.

(4) IN SELECTING MCO's THROUGH COMPETITIVE BIDDING, THE STATE DEPARTMENT SHALL GIVE PREFERENCE TO THOSE MCO's THAT HAVE EXECUTED CONTRACTS FOR SERVICES WITH ONE OR MORE ECP. IN SELECTING MCO's, THE STATE DEPARTMENT SHALL NOT PENALIZE AN MCO FOR PAYING COST-BASED REIMBURSEMENT TO FEDERALLY QUALIFIED HEALTH CENTERS AS DEFINED IN THE "SOCIAL SECURITY ACT".

(5) (a) NOTWITHSTANDING ANY WAIVERS AUTHORIZED BY THE FEDERAL DEPARTMENT OF HEALTH AND HUMAN SERVICES, EACH CONTRACT BETWEEN THE STATE DEPARTMENT AND AN MCO SELECTED TO PARTICIPATE IN THE STATEWIDE MANAGED CARE! SYSTEM UNDER THIS SUBPART 2 SHALL COMPLY WITH THE REQUIREMENTS OF 42 U.S.C. SEC. 1396a (a) (23) (B).

(b) EACH MCO SHALL ADVISE ITS ENROLLEES OF THE SERVICES AVAILABLE PURSUANT TO THIS SUBSECTION (5).

(6) NOTHING IN THIS SUBPART 2 SHALL BE CONSTRUED TO CREATE AN EXEMPTION FROM THE APPLICABLE PROVISIONS OF TITLE 10, C.R.S.

26-4-116. Quality measurements. (1) THE STATE DEPARTMENT SHALL MEASURE QUALITY PURSUANT TO THE FOLLOWING CRITERIA:

(a) QUALITY SHALL BE MEASURED AND CONSIDERED BASED UPON INDIVIDUALS AND GROUPS WITH THE SATISFACTION OF THE SERVICE RECEIVED ANALYZED AND COMPARED TO NONRECIPIENT POPULATIONS FOR THE SAME OR SIMILAR SERVICES WHEN AVAILABLE.

(b) QUALITY SHALL FOCUS ON HEALTH STATUS OR MAINTENANCE OF

THE INDIVIDUAL'S HIGHEST LEVEL OF FUNCTIONING, WITHOUT STRICT ADHERENCE TO STATISTICAL NORMS.

(2) THE STATE DEPARTMENT SHALL PROMULGATE RULES AND REGULATIONS TO CLARIFY AND ADMINISTER QUALITY MEASUREMENTS.

**26-4-117. Required features of managed care system.**

(1) **General features.** ALL MEDICAID MANAGED CARE PROGRAMS SHALL CONTAIN THE FOLLOWING GENERAL FEATURES, IN ADDITION TO OTHERS THAT THE STATE DEPARTMENT AND THE MEDICAL SERVICES BOARD CONSIDER NECESSARY FOR THE EFFECTIVE AND COST-EFFICIENT OPERATION OF THOSE PROGRAMS:

(a) **Recipient selection of MCO's.** (I) THE GENERAL ASSEMBLY FINDS THAT THE ABILITY OF RECIPIENTS TO CHOOSE AMONG COMPETING HEALTH PLANS OR HEALTH DELIVERY SYSTEMS IS AN IMPORTANT TOOL IN ENCOURAGING SUCH PLANS AND DELIVERY SYSTEMS TO COMPETE FOR ENROLLEES ON THE BASIS OF QUALITY AND ACCESS. THE STATE DEPARTMENT SHALL, TO THE EXTENT IT DETERMINES FEASIBLE, PROVIDE MEDICAID-ELIGIBLE RECIPIENTS A CHOICE AMONG COMPETING MCO'S AND A CHOICE AMONG PROVIDERS WITHIN AN MCO. CONSISTENT WITH FEDERAL REQUIREMENTS AND RULES PROMULGATED BY THE MEDICAL SERVICES BOARD, THE STATE DEPARTMENT IS AUTHORIZED TO ASSIGN A MEDICAID RECIPIENT TO A PARTICULAR MCO OR PRIMARY CARE PHYSICIAN IF:

(A) NO OTHER MCO OR PRIMARY CARE PHYSICIAN HAS THE CAPACITY OR EXPERTISE NECESSARY TO SERVE THE RECIPIENT; OR

(B) A RECIPIENT DOES NOT RESPOND WITHIN TWENTY DAYS AFTER THE DATE OF A SECOND NOTIFICATION OF A REQUEST FOR SELECTION OF AN MCO OR PRIMARY CARE PHYSICIAN SENT NOT LESS THAN FORTY-FIVE DAYS AFTER DELIVERY OF A FIRST NOTIFICATION.

(II) CONSUMERS SHALL BE INFORMED OF THE CHOICES AVAILABLE IN THEIR AREA BY APPROPRIATE SOURCES OF INFORMATION AND COUNSELING. **THIS** SHALL INCLUDE AN INDEPENDENT, OBJECTIVE FACILITATOR ACTING UNDER THE SUPERVISION OF THE STATE DEPARTMENT. THE STATE DEPARTMENT SHALL CONTRACT FOR THE FACILITATOR THROUGH A COMPETITIVE BIDDING PROCESS. THIS FUNCTION SHALL ENSURE THAT CONSUMERS HAVE INFORMED CHOICE AMONG AVAILABLE OPTIONS TO ASSURE THE FULLEST POSSIBLE VOLUNTARY PARTICIPATION IN MANAGED CARE. **THE** FACILITATOR SHALL ATTEMPT TO COLLECT AND CONSIDER, AT A MINIMUM, A CONSUMER'S USUAL AND HISTORIC SOURCES OF CARE,

LINGUISTIC NEEDS, SPECIAL MEDICAL NEEDS, AND TRANSPORTATION NEEDS. THE FACILITATOR SHALL, IF THE ENROLLEE REQUESTS, ACT AS THE ENROLLEE'S REPRESENTATIVE IN RESOLVING COMPLAINTS AND GRIEVANCES WITH THE MCO. THE DEPARTMENT, IN CONJUNCTION ~~WITH~~ THE MEDICAL SERVICES BOARD, SHALL ADOPT REGULATIONS SETTING FORTH MINIMUM DISCLOSURE REQUIREMENTS FOR ALL MCO'S. ONCE A RECIPIENT IS ENROLLED IN AN MCO, THE RECIPIENT MAY NOT CHANGE TO A DIFFERENT MCO FOR A PERIOD OF ~~SIX~~ MONTHS EXCEPT FOR GOOD CAUSE AS DETERMINED BY THE STATE DEPARTMENT. GOOD CAUSE SHALL INCLUDE BUT NEED NOT BE LIMITED TO ADMINISTRATIVE ERROR AND AN MCO'S INABILITY TO PROVIDE ITS COVERED SERVICES TO A RECIPIENT AFTER REASONABLE EFFORTS ON THE PART OF THE MCO AND THE RECIPIENT, AS DEFINED BY THE MEDICAL SERVICES BOARD. BASED UPON ITS ASSESSMENT OF ANY SPECIAL NEEDS OF RECIPIENTS WITH COGNITIVE DISABILITIES, THE MEDICAL SERVICES BOARD MAY ADOPT RULES RELATING TO ANY NECESSARY GOOD CAUSE PROVISIONS FOR RECIPIENTS WITH COGNITIVE DISABILITIES WHO ~~ARE~~ ASSIGNED TO A PARTICULAR MCO PURSUANT TO SUBPARAGRAPH (I) OF THIS PARAGRAPH **(a)**.

(III) WHEN ELIGIBLE CONSUMERS CHOOSE TO CHANGE OR DISENROLL FROM ~~THEIR~~ SELECTED MCO, THE STATE DEPARTMENT SHALL MONITOR AND GATHER DATA ABOUT THE REASONS FOR DISENROLLING, INCLUDING DENIAL OF ENROLLMENT OR DISENROLLMENT DUE TO AN ACT OR OMISSION OF AN MCO. THE STATE DEPARTMENT SHALL ANALYZE THIS DATA AND PROVIDE FEEDBACK TO THE PLANS OR PROVIDERS AND SHALL USE THE INFORMATION IN THE STATE DEPARTMENT'S CONTRACTING AND QUALITY ASSURANCE EFFORTS. PERSONS WHO HAVE BEEN DENIED ENROLLMENT OR HAVE DISENROLLED DUE TO AN ACT OR OMISSION OF AN MCO MAY SEEK REVIEW BY AN INDEPENDENT HEARING OFFICER, AS PROVIDED FOR AND REQUIRED UNDER FEDERAL LAW AND ANY STATE STATUTE OR REGULATION.

**(b) Complaints and grievances.** EACH MCO SHALL UTILIZE A COMPLAINT AND GRIEVANCE PROCEDURE AND A PROCESS FOR EXPEDITED REVIEWS THAT COMPLY WITH REGULATIONS ESTABLISHED BY THE STATE DEPARTMENT IN CONFORMITY WITH FEDERAL LAW. THE COMPLAINT AND GRIEVANCE PROCEDURE SHALL PROVIDE A MEANS BY WHICH ENROLLEES MAY COMPLAIN ABOUT OR GRIEVE ANY ACTION OR FAILURE TO ACT THAT IMPACTS AN ENROLLEE'S ACCESS TO, SATISFACTION WITH, OR THE QUALITY OF HEALTH ~~CARE~~ SERVICES, TREATMENTS, OR PROVIDERS. THE PROCESS FOR EXPEDITED REVIEWS SHALL PROVIDE A MEANS BY WHICH AN ENROLLEE MAY COMPLAIN AND SEEK RESOLUTION CONCERNING ANY ACTION OR FAILURE TO ACT IN ~~AN~~ EMERGENCY SITUATION THAT IMMEDIATELY IMPACTS THE ENROLLEE'S ACCESS TO QUALITY HEALTH CARE SERVICES, TREATMENTS, OR

PROVIDERS. **AN** ENROLLEE SHALL BE ENTITLED TO DESIGNATE A REPRESENTATIVE, INCLUDING BUT NOT LIMITED TO AN ATTORNEY, A FACILITATOR DESCRIBED IN PARAGRAPH (a) OF THIS SUBSECTION (1), A LAY ADVOCATE, OR THE ENROLLEE'S PHYSICIAN, TO FILE AND PURSUE A GRIEVANCE OR EXPEDITED REVIEW ON BEHALF OF THE ENROLLEE. THE PROCEDURE SHALL ALLOW FOR THE UNENCUMBERED PARTICIPATION OF PHYSICIANS. **AN** ENROLLEE WHOSE COMPLAINT OR GRIEVANCE IS NOT RESOLVED TO HIS OR HER SATISFACTION BY A PROCEDURE DESCRIBED IN THIS PARAGRAPH (b) OR WHO CHOOSES TO FOREGO A PROCEDURE DESCRIBED IN THIS PARAGRAPH (b) SHALL BE ENTITLED TO REQUEST A SECOND-LEVEL REVIEW BY ~~AN~~ INDEPENDENT HEARING OFFICER, FURTHER JUDICIAL REVIEW, OR BOTH, AS PROVIDED FOR BY FEDERAL LAW AND ANY STATE STATUTE OR REGULATION. ~~THE~~ STATE DEPARTMENT MAY ALSO PROVIDE BY REGULATION FOR ARBITRATION AS AN OPTIONAL ALTERNATIVE TO THE COMPLAINT AND GRIEVANCE PROCEDURE SET FORTH IN THIS PARAGRAPH (b) TO THE EXTENT THAT SUCH REGULATIONS DO NOT VIOLATE ANY OTHER STATE OR FEDERAL STATUTORY OR CONSTITUTIONAL REQUIREMENTS.

(c) **Billing medicaid recipients.** NOTWITHSTANDING ANY FEDERAL REGULATIONS OR THE GENERAL PROHIBITION OF SECTION 26-4-403 AGAINST PROVIDERS BILLING MEDICAID RECIPIENTS, A PROVIDER MAY BILL A MEDICAID RECIPIENT WHO IS ENROLLED WITH A SPECIFIC MEDICAID PRIMARY CARE PHYSICIAN OR MCO AND, IN CIRCUMSTANCES DEFINED BY THE REGULATIONS OF THE MEDICAL SERVICES BOARD, RECEIVES CARE FROM A MEDICAL PROVIDER OUTSIDE THAT ORGANIZATION'S NETWORK OR WITHOUT REFERRAL BY THE RECIPIENT'S PRIMARY CARE PHYSICIAN.

(d) **Marketing.** IN MARKETING COVERAGE TO MEDICAID RECIPIENTS, ALL MCO'S SHALL COMPLY WITH ALL APPLICABLE PROVISIONS OF TITLE 10, C.R.S., REGARDING HEALTH PLAN MARKETING. THE MEDICAL SERVICES **BOARD IS** AUTHORIZED TO PROMULGATE RULES CONCERNING THE PERMISSIBLE MARKETING OF MEDICAID MANAGED CARE. THE PURPOSES OF SUCH RULES SHALL INCLUDE BUT NOT BE LIMITED TO THE AVOIDANCE OF BIASED SELECTION AMONG THE CHOICES AVAILABLE TO MEDICAID RECIPIENTS.

(e) **Prescription drugs.** ALL MCO'S SHALL PROVIDE PRESCRIPTION DRUG COVERAGE AS PART OF A COMPREHENSIVE HEALTH BENEFIT AND **WITH** RESPECT TO ANY FORMULARY OR OTHER ACCESS RESTRICTIONS:

(I) THE MCO SHALL SUPPLY PARTICIPATING PROVIDERS WHO MAY PRESCRIBE PRESCRIPTION DRUGS FOR MCO ENROLLEES WITH A CURRENT COPY OF SUCH FORMULARY OR OTHER ACCESS RESTRICTIONS, INCLUDING

INFORMATION ABOUT COVERAGE, PAYMENT, OR ANY REQUIREMENT FOR PRIOR AUTHORIZATION; AND

(II) THE MCO SHALL PROVIDE TO ALL MEDICAID RECIPIENTS AT PERIODIC INTERVALS, AND PRIOR TO AND DURING ENROLLMENT UPON REQUEST, CLEAR AND CONCISE INFORMATION ABOUT THE PRESCRIPTION DRUG PROGRAM IN LANGUAGE UNDERSTANDABLE TO THE MEDICAID RECIPIENTS, INCLUDING INFORMATION ABOUT SUCH FORMULARY OR OTHER ACCESS RESTRICTIONS AND PROCEDURES FOR GAINING ACCESS TO PRESCRIPTION DRUGS, INCLUDING OFF-FORMULARY PRODUCTS.

(f) **Access to prescription drugs.** (I) THE STATE DEPARTMENT SHALL ENCOURAGE AN MCO TO SOLICIT COMPETITIVE BIDS FOR THE PRESCRIPTION DRUG BENEFIT AND DISCOURAGE AN MCO FROM CONTRACTING FOR THE PRESCRIPTION DRUG BENEFIT WITH A SOLE SOURCE PROVIDER AS MUCH AS POSSIBLE. THE STATE DEPARTMENT'S REPORTS REQUIRED BY SECTION **26-4-121** SHALL INCLUDE A SUMMARY OF EACH MCO'S PHARMACY NETWORK BY GEOGRAPHIC CATCHMENT AREA.

(II) **IF** AN MCO SOLICITS COMPETITIVE BIDS FOR THE PRESCRIPTION DRUG BENEFIT, THE MCO SHALL REQUEST BIDS FROM EACH PHARMACY PROVIDER LOCATED IN THE GEOGRAPHIC AREAS IN WHICH THE MCO IS SOLICITING BIDS. **ALL** MCO'S SHALL FOLLOW A REASONABLE STANDARD FOR RECIPIENT ACCESS TO PRESCRIPTION DRUGS. AT A MINIMUM, THE STATE DEPARTMENT SHALL VERIFY COMPLIANCE WITH THESE REQUIREMENTS BY REVIEWING EVIDENCE PROVIDED BY THE COMMISSIONER OF INSURANCE CONCERNING COMPLIANCE WITH ANY STANDARDS OR GUIDANCE ESTABLISHED BY THE COMMISSIONER OF INSURANCE FOR CONSUMER ACCESS TO PRESCRIPTION DRUGS.

(III) THE STANDARDS AND GUIDANCE FROM THE INSURANCE COMMISSIONER SHALL BE BASED ON THE FOLLOWING:

(A) PROCEDURES THAT AN MCO SHALL FOLLOW TO **ENSURE** THAT PHARMACIES IN RURAL COMMUNITIES WITH FEWER THAN TWENTY-FIVE THOUSAND PERSONS **HAVE** THE OPPORTUNITY TO JOIN RETAIL PRESCRIPTION DRUG NETWORKS IF THEY AGREE TO REASONABLE CONTRACT **TERMS** ;

(B) PROCEDURES THAT AN MCO SHALL FOLLOW TO NOTIFY THE PHARMACY COMMUNITY OF COMPETITIVELY BID PRESCRIPTION DRUG CONTRACTS;

(C) PROCEDURES THAT AN MCO SHALL FOLLOW TO GIVE ALL

PHARMACIES AND PHARMACY NETWORKS A FAIR OPPORTUNITY TO PARTICIPATE IN PRESCRIPTION DRUG CONTRACTS;

(D) ANY RELATED MATTERS THAT ARE DESIGNED TO EXPAND CONSUMER ACCESS TO PHARMACY SERVICES; AND

(E) **ANY RELATED MATTERS** THAT WILL ENHANCE THE FUNCTIONING OF THE FREE MARKET SYSTEM **WITH** RESPECT TO PHARMACIES.

(IV) NOTHING IN THIS PARAGRAPH (f) SHALL APPLY TO THE DELIVERY OF PRESCRIPTION DRUG BENEFITS TO RECIPIENTS ENROLLED IN AN MCO WHO ARE RESIDENTS OF ANURSING FACILITY.

**(g) Continuity of care.** (I) NEW ENROLLEES, WITH SPECIAL NEEDS AS DEFINED BY THE MEDICAL SERVICES BOARD AND AS CERTIFIED BY A NON-PLAN PHYSICIAN, MAY CONTINUE TO SEE A NON-PLAN PROVIDER FOR **SIXTY** DAYS FROM THE DATE OF ENROLLMENT IN AN MCO, IF THE ENROLLEE IS IN AN ONGOING COURSE OF TREATMENT WITH THE PREVIOUS PROVIDER AND ONLY IF THE PREVIOUS PROVIDER AGREES:

(A) TO ACCEPT REIMBURSEMENT FROM THE MCO AS PAYMENT IN FULL AT RATES ESTABLISHED BY THE MCO THAT SHALL BE NO MORE THAN THE LEVEL OF REIMBURSEMENT APPLICABLE TO SIMILAR PROVIDERS WITHIN THE MCO'S GROUP OR NETWORK FOR SUCH SERVICES;

(B) TO ADHERE TO THE MCO'S QUALITY ASSURANCE REQUIREMENTS AND TO PROVIDE TO THE MCO NECESSARY MEDICAL INFORMATION RELATED TO SUCH CARE; AND

(C) TO OTHERWISE ADHERE TO THE MCO'S POLICIES AND PROCEDURES INCLUDING BUT NOT LIMITED TO PROCEDURES REGARDING REFERRALS, OBTAINING PRE-AUTHORIZATIONS, AND MCO-APPROVED TREATMENT PLANS.

(II) NEW ENROLLEES WHO ARE IN THEIR SECOND OR THIRD TRIMESTER OF PREGNANCY MAY CONTINUE TO SEE THEIR PRACTITIONER UNTIL THE COMPLETION OF POST-PARTUM CARE DIRECTLY RELATED TO THE DELIVERY ONLY IF THE PRACTITIONER AGREES:

(A) TO ACCEPT REIMBURSEMENT FROM THE MCO AS PAYMENT IN FULL AT RATES ESTABLISHED BY THE MCO THAT SHALL BE NO MORE THAN THE LEVEL OF REIMBURSEMENT APPLICABLE TO SIMILAR PROVIDERS WITHIN THE MCO'S GROUP OR NETWORK FOR SUCH SERVICES;

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(B) TO ~~ADHERE~~ TO THE MCO'S QUALITY ASSURANCE REQUIREMENTS AND TO PROVIDE TO THE MCO NECESSARY MEDICAL INFORMATION RELATED TO SUCH CARE; AND

(C) TO OTHERWISE ADHERE TO THE MCO'S POLICIES AND PROCEDURES INCLUDING BUT NOT LIMITED TO PROCEDURES REGARDING REFERRALS, OBTAINING PRE-AUTHORIZATIONS, AND MCO-APPROVED TREATMENT PLANS.

(III) NEW ENROLLEES WITH SPECIAL NEEDS AS DEFINED BY THE STATE DEPARTMENT MAY CONTINUE TO SEE ANCILLARY PROVIDERS AT THE LEVEL OF CARE RECEIVED PRIOR TO ENROLLMENT FOR A PERIOD OF UP TO SEVENTY-FIVE DAYS. THE TERMS AND CONDITIONS, INCLUDING REIMBURSEMENT RATES, SHALL REMAIN THE SAME AS PRIOR TO ENROLLMENT IF THE PROVIDER AND ENROLLEE AGREE TO WORK IN GOOD FAITH WITH THE MCO TOWARD A TRANSITION.

(IV) **THIS** PARAGRAPH (g) SHALL NOT BE CONSTRUED TO REQUIRE AN MCO TO PROVIDE COVERAGE FOR BENEFITS NOT OTHERWISE COVERED.

**26-4-118. State department recommendations - primary care physician program - special needs - annual report.** (1) (a) IT IS THE GENERAL ASSEMBLY'S INTENT THAT THE STATE OF COLORADO HAVE A STATEWIDE MANAGED CARE SYSTEM FOR MEDICAL ASSISTANCE RECIPIENTS WITH AT LEAST SEVENTY-FIVE PERCENT ENROLLMENT. THE GENERAL ASSEMBLY, HOWEVER, RECOGNIZES THE NEED FOR THE STATE DEPARTMENT TO EXPLORE **VARIOUS** METHODS OF PROVIDING MANAGED CARE FOR CERTAIN MEDICAL ASSISTANCE POPULATIONS. THE **METHODS** MAY RANGE FROM UNIQUE MANAGED CARE CONTRACTS WITH SPECIAL REIMBURSEMENT ARRANGEMENTS TO SPECIFIC PROVIDERS OR SERVICES. NO LATER **THAN** THE FIRST DAY OF DECEMBER OF EACH FISCAL YEAR OF THE IMPLEMENTATION PERIOD PROVIDED IN SECTION 26-4-113(2), THE STATE DEPARTMENT SHALL MAKE RECOMMENDATIONS IN A **WRITTEN** REPORT TO THE GENERAL ASSEMBLY WITH RESPECT TO NECESSARY EXEMPTIONS FROM THE REQUIREMENT THAT MANAGED CARE BE IMPLEMENTED FOR SEVENTY-FIVE PERCENT OF THE MEDICAL ASSISTANCE POPULATION ON A STATEWIDE BASIS NO LATER THAN JULY 1, 2000.

(b) THE GENERAL ASSEMBLY RECOGNIZES THAT CAPITATED MANAGED CARE PROGRAMS MAY NOT BE APPROPRIATE FOR SOME SEGMENTS OF THE MEDICAID POPULATION. FOR EXAMPLE, RURAL MEDICAID RECIPIENTS MAY NOT HAVE A CHOICE OF CAPITATED MCO'S AND SPECIAL NEEDS POPULATIONS MAY NOT BE ABLE TO RECEIVE NECESSARY SERVICES FROM

CAPITATED MCO's.

(2) (a) THE PRIMARY CARE PHYSICIAN PROGRAM REQUIRES MEDICAID RECIPIENTS TO SELECT A PRIMARY CARE PHYSICIAN WHO IS SOLELY AUTHORIZED TO PROVIDE PRIMARY CARE AND REFERRAL TO ALL NECESSARY SPECIALTY SERVICES. TO ENCOURAGE LOW-COST AND ACCESSIBLE CARE, THE STATE DEPARTMENT IS AUTHORIZED TO UTILIZE THE PRIMARY CARE PHYSICIAN PROGRAM TO DELIVER SERVICES TO APPROPRIATE MEDICAID RECIPIENTS.

(b) THE STATE DEPARTMENT SHALL ESTABLISH PROCEDURES AND CRITERIA FOR THE COST-EFFECTIVE OPERATION OF THE PRIMARY CARE PHYSICIAN PROGRAM, INCLUDING BUT NOT LIMITED TO SUCH MATTERS AS APPROPRIATE ELIGIBILITY CRITERIA AND GEOGRAPHIC AREAS SERVED **BY** THE PROGRAMS.

**26-4-119. Capitation rates - risk adjustments.** (1) THE STATE DEPARTMENT SHALL **MAKE** PREPAID CAPITATION PAYMENT TO MANAGED CARE ORGANIZATIONS BASED UPON A DEFINED SCOPE OF SERVICES. PAYMENTS SHALL BE BASED UPON THE FOLLOWING UPPER AND LOWER LIMITS:

(a) THE UPPER LIMIT SHALL NOT EXCEED NINETY-FIVE PERCENT OF THE COST OF PROVIDING THESE SAME SERVICES ON AN ACTUARIALLY EQUIVALENT NON-MANAGED CARE ENROLLED COLORADO MEDICAID POPULATION GROUP. **THIS** LIMIT MAY BE MODIFIED BASED UPON ANY FEDERAL REQUIREMENTS FOR REIMBURSEMENT TO FEDERALLY QUALIFIED HEALTH CLINICS AS DEFINED **IN** THE FEDERAL "SOCIAL SECURITY ACT".

(b) THE LOWER LIMIT SHALL BE A MARKET RATE SET THROUGH THE COMPETITIVE BID PROCESS FOR A SET **OF** DEFINED SERVICES. THE STATE DEPARTMENT SHALL ONLY USE MARKET RATE BIDS THAT DO NOT DISCRIMINATE AND ARE ADEQUATE TO **ASSURE** QUALITY, NETWORK SUFFICIENCY, AND LONGTERM COMPETITIVENESS IN THE MEDICAID MANAGED CARE MARKET. A CERTIFICATION OF A QUALIFIED ACTUARY, RETAINED BY THE STATE DEPARTMENT, TO THE APPROPRIATE LOWER LIMIT SHALL BE CONCLUSIVE EVIDENCE OF THE STATE DEPARTMENT'S COMPLIANCE WITH THE REQUIREMENTS OF THIS PARAGRAPH (b). FOR THE PURPOSES OF **THIS** PARAGRAPH (b), A "QUALIFIED ACTUARY" SHALL BE A PERSON DEEMED AS SUCH UNDER REGULATIONS PROMULGATED BY THE COMMISSIONER OF INSURANCE.

(2) **THE** STATE DEPARTMENT SHALL DEVELOP CAPITATION RATES FOR

MCO'S THAT INCLUDE RISK ADJUSTMENTS, REINSURANCE, OR STOP-LOSS FUNDING METHODS. PAYMENTS TO PLANS MAY VARY WHEN IT IS **SHOWN** THROUGH DIAGNOSES OR OTHER RELEVANT DATA THAT CERTAIN POPULATIONS ARE EXPECTED TO COST MORE OR LESS THAN THE CAPITATED POPULATION AS A WHOLE.

(3) THE MEDICAL SERVICES BOARD, IN CONSULTATION WITH RECOGNIZED MEDICAL AUTHORITIES, SHALL DEVELOP A DEFINITION OF SPECIAL NEEDS POPULATIONS THAT INCLUDES EVIDENCE OF DIAGNOSED OR MEDICALLY CONFIRMED HEALTH CONDITIONS. THE STATE DEPARTMENT SHALL DEVELOP A METHOD FOR ADJUSTING PAYMENTS TO PLANS FOR SUCH SPECIAL NEEDS POPULATIONS WHEN DIAGNOSES OR OTHER RELEVANT DATA INDICATES THESE SPECIAL NEEDS POPULATIONS WOULD COST SIGNIFICANTLY MORE THAN SIMILARLY CAPITATED POPULATIONS.

(4) THE RISK ADJUSTMENT, REINSURANCE, OR STOP-LOSS FUNDING METHODS DEVELOPED BY THE STATE DEPARTMENT PURSUANT TO SUBSECTION (2) OF THIS SECTION SHALL BE IMPLEMENTED NO LATER THAN JULY 1, 1998, ON THE CONDITION THAT THE DIAGNOSES AND RELEVANT DATA ARE MADE AVAILABLE TO THE STATE DEPARTMENT IN SUFFICIENT TIME TO ALLOW THE RATES TO BE SET BY JULY 1, 1998.

(5) UNDER NO CIRCUMSTANCES SHALL THE **RISK** ADJUSTMENTS, REINSURANCE, OR STOP-LOSS METHODS DEVELOPED BY THE STATE DEPARTMENT PURSUANT TO SUBSECTION (2) OF THIS SECTION CAUSE THE AVERAGE PER CAPITA MEDICAID PAYMENT TO A PLAN TO BE GREATER THAN THE PROJECTED MEDICAID EXPENDITURES FOR TREATING MEDICAID ENROLLEES OF THAT PLAN UNDER FEE-FOR-SERVICE MEDICAID.

(6) THE STATE DEPARTMENT MAY DEVELOP QUALITY INCENTIVE PAYMENTS TO RECOGNIZE SUPERIOR QUALITY OF CARE OR SERVICE PROVIDED BY A MANAGED CARE PLAN.

**26-4-120. State department - privatization.** (1) THE GENERAL ASSEMBLY FINDS THAT THE STATEWIDE MANAGED CARE SYSTEM IS A PROGRAM UNDER WHICH THE PRIVATE SECTOR HAS A GREAT DEAL OF EXPERIENCE IN MAKING VARIOUS HEALTH CARE PLANS AVAILABLE TO THE PRIVATE SECTOR AND SERVING AS THE LIAISON BETWEEN LARGE EMPLOYERS AND HEALTH CARE PROVIDERS, INCLUDING BUT NOT LIMITED TO HEALTH MAINTENANCE ORGANIZATIONS. THE GENERAL ASSEMBLY THEREFORE DETERMINES THAT A STATEWIDE MANAGED CARE SYSTEM INVOLVES DUTIES SIMILAR TO DUTIES CURRENTLY OR PREVIOUSLY PERFORMED BY STATE EMPLOYEES BUT IS DIFFERENT IN SCOPE AND POLICY OBJECTIVES FROM THE

STATE MEDICAL ASSISTANCE PROGRAM.

(2) **TO** THAT END, PURSUANT TO SECTION **24-50-504 (2) (a), C.R.S.**, THE STATE DEPARTMENT SHALL ENTER **INTO** PERSONAL SERVICES CONTRACTS THAT CREATE AN INDEPENDENT CONTRACTOR RELATIONSHIP FOR THE ADMINISTRATION OF NOT LESS THAN TWENTY PERCENT OF THE STATEWIDEMANAGED CARE SYSTEM. **THE** STATE DEPARTMENT SHALL ENTER INTO PERSONAL SERVICE CONTRACTS FOR THE ADMINISTRATION OF THE MANAGED CARE SYSTEM ACCORDING TO THE IMPLEMENTATION OF THE STATEWIDE MANAGED CARE SYSTEM IN ACCORDANCE WITH SECTION **26-4-113 (2)**.

(3) IN CONNECTION WITH THE REQUIREMENT SET FORTH IN SUBSECTION (2) OF THIS SECTION, THE STATE DEPARTMENT SHALL INCLUDE RECOMMENDATIONS CONCERNING PRIVATIZATION OF THE ADMINISTRATION OF THE MANAGED CARE SYSTEM IN ITS ANNUAL REPORT REQUIRED BY SECTION **26-4-118**.

(4) THE IMPLEMENTATION OF THIS SECTION IS CONTINGENT UPON:

(a) LEGISLATIVE REVIEW **OF** THE COST-EFFECTIVENESS OF PRIVATIZATION **AND** THE EXTENT TO WHICH SUCH PRIVATIZATION ENHANCES THE QUALITY OF CARE TO RECIPIENTS; AND

(b) A FINDING BY THE STATE PERSONNEL DIRECTOR THAT ANY OF THE CONDITIONS OF SECTION **24-50-504 (2), C.R.S.**, HAVE BEEN MET OR THAT THE CONDITIONS OF SECTION **24-50-503 (1), C.R.S.**, HAVE BEEN MET.

**26-4-121. Data collection for managed care programs - reports.**

(1) IN ADDITION TO ANY OTHER DATA COLLECTION OR REPORTING REQUIREMENTS SET FORTH IN **THIS** ARTICLE, THE STATE DEPARTMENT SHALL ACCESS **AND** COMPILE DATA CONCERNING HEALTH DATA AND OUTCOMES. IN ADDITION, NO LATER THAN JULY 1, **1998**, THE STATE DEPARTMENT SHALL CONDUCT OR SHALL CONTRACT WITH AN INDEPENDENT EVALUATOR TO CONDUCT A QUALITY ASSURANCE ANALYSIS OF EACH MANAGED CARE PROGRAM IN THE STATE FOR MEDICAL ASSISTANCE RECIPIENTS. NO LATER THAN JULY 1, **1999**, AND EACH FISCAL YEAR THEREAFTER, THE STATE DEPARTMENT, USING THE COMPILED DATA AND RESULTS FROM THE QUALITY ASSURANCE ANALYSIS, SHALL **SUBMIT** A REPORT TO THE HOUSE AND SENATE COMMITTEES ON HEALTH, ENVIRONMENT, WELFARE, AND INSTITUTIONS ON THE COST-EFFICIENCY OF EACH MANAGED CARE PROGRAM OR COMPONENT THEREOF, WITH RECOMMENDATIONS CONCERNING STATEWIDE IMPLEMENTATION OF THE RESPECTIVE PROGRAMS OR COMPONENTS. FOR THE

PURPOSES OF THIS SUBSECTION (1), "QUALITY ASSURANCE" MEANS COSTS WEIGHED AGAINST BENEFITS PROVIDED TO CONSUMERS, HEALTH OUTCOMES OR MAINTENANCE OF THE INDIVIDUAL'S HIGHEST LEVEL OF FUNCTIONING, AND THE OVERALL CHANGE IN THE HEALTH STATUS OF THE POPULATION SERVED. THE STATE DEPARTMENT'S REPORT SHALL ADDRESS CAPITATION, INCLUDING METHODS FOR ADJUSTING RATES BASED ON RISK ALLOCATIONS, FEES-FOR-SERVICES, COPAYMENTS, CHRONICALLY ILL POPULATIONS, LONG-TERM CARE, COMMUNITY-SUPPORTED SERVICES, AND THE ENTITLEMENT STATUS OF MEDICAL ASSISTANCE. THE STATE DEPARTMENT'S REPORT SHALL INCLUDE A COMPARISON OF THE EFFECTIVENESS OF THE MCO PROGRAM AND THE PRIMARY CARE PHYSICIAN PROGRAM BASED UPON COMMON PERFORMANCE STANDARDS THAT SHALL INCLUDE BUT NOT BE LIMITED TO RECIPIENT SATISFACTION.

(2) IN ADDITION, THE STATE DEPARTMENT OF HUMAN SERVICES, IN CONJUNCTION WITH THE STATE DEPARTMENT, SHALL CONTINUE ITS EXISTING EFFORTS, WHICH INCLUDE OBTAINING AND CONSIDERING CONSUMER INPUT, TO DEVELOP MANAGED CARE SYSTEMS FOR THE DEVELOPMENTALLY DISABLED POPULATION AND TO CONSIDER A PILOT PROGRAM FOR A CERTIFICATE SYSTEM TO ENABLE THE DEVELOPMENTALLY DISABLED POPULATION TO PURCHASE MANAGED CARE SERVICES OR FEE-FOR-SERVICE CARE, INCLUDING LONG-TERM CARE COMMUNITY SERVICES. THE DEPARTMENT OF HUMAN SERVICES SHALL NOT IMPLEMENT ANY MANAGED CARE SYSTEM FOR DEVELOPMENTALLY DISABLED SERVICES WITHOUT THE EXPRESS APPROVAL OF THE JOINT BUDGET COMMITTEE. ANY PROPOSED IMPLEMENTATION OF FULLY CAPITATED MANAGED CARE IN THE DEVELOPMENTAL DISABILITIES COMMUNITY SERVICE SYSTEM SHALL REQUIRE LEGISLATIVE REVIEW.

(3) IN ADDITION TO ANY OTHER DATA COLLECTION AND REPORTING REQUIREMENTS, EACH MANAGED CARE ORGANIZATION SHALL SUBMIT THE FOLLOWING TYPES OF DATA TO THE STATE DEPARTMENT OR ITS AGENT:

- (a) MEDICAL ACCESS;
- (b) CONSUMER OUTCOMES BASED ON STATISTICS MAINTAINED ON INDIVIDUAL CONSUMERS AS WELL AS THE TOTAL CONSUMER POPULATIONS SERVED;
- (c) CONSUMER SATISFACTION;
- (d) CONSUMER UTILIZATION;

(e) HEALTH STATUS OF CONSUMERS; AND

(f) UNCOMPENSATED CARE DELIVERED.

**26-4-122. Integrated care and financing project.** (1) THE STATE DEPARTMENT ~~THIS~~ IS AUTHORIZED TO OVERSEE AND ADMINISTER THE INTEGRATED CARE AND FINANCING PROJECT TO STUDY THE INTEGRATION OF ACUTE AND LONGTERM CARE WITHIN THE FOLLOWING GUIDELINES:

(a) THE PROJECT SHALL BE CONDUCTED IN A COUNTY OR COUNTIES SELECTED BY THE STATE DEPARTMENT THAT HAVE AT LEAST ONE YEAR'S EXPERIENCE IN PROVIDING MANAGED CARE FOR THE MEDICAL ASSISTANCE POPULATION AND HAS A SYSTEM FOR MANAGING LONGTERM CARE, INCLUDING REFERRAL TO APPROPRIATE SERVICES, CASE PLANNING, AND BROKERING AND MONITORING OF SERVICES.

(b) ~~THE~~ STATE DEPARTMENT SHALL COMBINE ACUTE AND LONGTERM CARE IN A MANAGED CARE ENVIRONMENT FOR THE PURPOSE OF CREATING COST-EFFICIENT AND ECONOMICAL CLINICAL APPROACHES TO SERVING THE MEDICAL ASSISTANCE POPULATION IN NEED OF BOTH TYPES OF CARE.

(c) THE STATE DEPARTMENT SHALL MAINTAIN APPLICABLE FEDERAL OR STATE ELIGIBILITY REQUIREMENTS.

(d) IN NO EVENT SHALL THE STATE DEPARTMENT REQUIRE ANY PERSON WHO IS ELIGIBLE FOR BOTH MEDICAL ASSISTANCE UNDER THE PROVISIONS OF ~~THIS~~ ARTICLE ~~AND~~ FOR ANOTHER THIRD-PARTY COVERAGE TO ENROLL IN AN MCO BEFORE JULY 1, 2000. NOTHING IN ~~THIS~~ PARAGRAPH (d) SHALL PREVENT THE STATE DEPARTMENT FROM PURCHASING THIRD-PARTY COVERAGE ON BEHALF OF A MEDICAID RECIPIENT.

(e) THE PROJECT SHALL BE FOR PERSONS ELIGIBLE FOR MEDICAL ASSISTANCE.

(f) PARTICIPANTS SHALL BE MEDICAL ASSISTANCE RECIPIENTS ENROLLED IN A HEALTH MAINTENANCE ORGANIZATION; EXCEPT THAT THE PROJECT SHALL NOT INCLUDE THE DELIVERY OF MENTAL HEALTH SERVICES AND DEVELOPMENTALLY DISABLED SERVICES, WHICH SERVICES SHALL CONTINUE TO BE PROVIDED THROUGH THE MENTAL HEALTH CAPITATION PROJECT AND THE DEVELOPMENTAL DISABILITIES SERVICES SYSTEM. PERSONS WITH DEVELOPMENTAL DISABILITIES AND MENTAL HEALTH NEEDS MAY PARTICIPATE IN THIS PROJECT FOR ALL THE SERVICES OFFERED BY THE

PROJECT.

(g) THE PROJECT SHALL ADOPT GOALS THAT **ENSURE**: INTEGRATED ACUTE AND LONGTERM MANAGED CARE RESULTS IN ADEQUATE ACCESS TO AND QUALITY OF HEALTH CARE; PARTICIPANT SATISFACTION AND IMPROVED PARTICIPANT HEALTH STATUS OR MAINTENANCE OF THE INDIVIDUAL'S HIGHEST LEVEL OF FUNCTIONING; AND SUFFICIENT COLLECTION OF HEALTH DATA AND PARTICIPANT OUTCOMES.

(h) THE STATE DEPARTMENT SHALL CONSULT WITH KNOWLEDGEABLE AND CONCERNED PERSONS IN THE STATE, INCLUDING CONSUMER ADVOCACY GROUPS, RECIPIENTS, AND CAREGIVERS.

(i) THE STATE MEDICAL SERVICES BOARD SHALL ADOPT RULES REQUIRING THE HEALTH MAINTENANCE ORGANIZATION TO ESTABLISH A COMPLAINT PROCESS FOR PARTICIPANTS DISSATISFIED WITH THE CARE PROVIDED UNDER THE PROJECT. IF A PARTICIPANT DISAGREES WITH THE ACTION TAKEN BY THE HEALTH MAINTENANCE ORGANIZATION, THE PARTICIPANT MAY SEEK REVIEW OF THE ACTION PURSUANT TO SECTION **25.5-1-107, C.R.S.** IN ADDITION, THE STATE MEDICAL SERVICES BOARD SHALL **ADOPT** A PROCEDURE UNDER WHICH A PARTICIPANT MAY DISENROLL FROM THE PROJECT AND CONTINUE ELIGIBILITY UNDER THE MEDICAL ASSISTANCE PROGRAM.

(j) IN ADDITION TO USING OTHER METHODS OF MEASURING PARTICIPANT SATISFACTION AND OUTCOMES, THE STATE DEPARTMENT SHALL CONDUCT RANDOM SURVEYS TO ASSESS PARTICIPANT SATISFACTION AND MEET WITH RECIPIENT GROUPS BEING SERVED BY THE PROJECT.

(2) THE PROJECT MAY BE EXPANDED TO OTHER DEMONSTRATION **SITES AND** MAY BE MODIFIED IN ACCORDANCE WITH THE PROVISIONS OF THIS SECTION BASED UPON EXPERIENCE IN INITIAL DEMONSTRATION SITES, AS PERMITTED BY ANY NECESSARY FEDERAL WAIVERS, **IN** CONSULTATION WITH RELEVANT STAKEHOLDERS. **THE** STATE DEPARTMENT IS AUTHORIZED TO IMPLEMENT THIS PROJECT STATEWIDE ONLY AFTER FULL REVIEW BY THE GENERAL ASSEMBLY AND ONLY TO THE EXTENT THAT FEDERAL WAIVERS ARE RECEIVED.

**26-4-123. Managed mental health services feasibility study - waiver - pilot program. [Formerly 26-4-528.]** (1) ~~(a)~~ The STATE department ~~of health care policy and financing~~ and the department of human services shall jointly conduct a feasibility study concerning management of mental health services under the "Colorado Medical

Assistance Act", which study shall consider a prepaid capitated system for providing comprehensive mental health services. In conducting the study, the STATE department ~~of health care policy and financing~~ and the department of human services shall:

~~(H)~~ (a) Consult with knowledgeable and concerned persons in the state, including low-income persons who are recipients of mental health services and providers of mental health services under the "Colorado Medical Assistance Act"; ~~and~~

~~(H)~~ (b) Consider the effect of any program on the provider or community mental health centers and clinics. Any prepaid capitated program shall, as much ~~as~~ possible, avoid exposing providers or community mental health centers and clinics to undue financial risk or reliance on supplemental revenues from state general funds, local revenues, or fee-for-service funds.

~~(b) Repealed.~~

(c) ~~CONSIDER THE EFFECT OF ANY PROGRAM ON THE COORDINATION OF PATIENTS' MEDICAL, CARE AND MENTAL, HEALTH CARE AND ON PATIENTS' ACCESS TO PRESCRIPTION MEDICINES, INCLUDING MEDICINES FOR THE TREATMENT OF MENTAL DISORDERS.~~

(2) The state department is authorized to seek a waiver of the requirements of Title XIX of the social security act to allow the state department to limit a recipient's freedom of choice of providers and to restrict reimbursement for mental health services to designated and contracted agencies.

(3) (a) If a determination is made by the STATE department ~~of health care policy and financing~~ and the department of human services, based on the feasibility study required in subsection (1) of this section, that the implementation of one or more model or proposed program modifications would be cost-effective, and if all necessary federal waivers are obtained, the STATE department ~~of health care policy and financing~~ shall establish a pilot prepaid capitated system for providing comprehensive mental health services. The STATE department ~~of health care policy and financing~~ shall promulgate rules ~~as~~ necessary for the implementation and administration of the pilot program. The pilot program shall terminate on July 1, 1997. If the pilot program is implemented, the STATE department ~~of health care policy and financing~~ and the department of human services shall submit to the house and senate committees on health, environment, welfare, and

~~institutions~~ on or before July 1, 1996, a preliminary status report on the pilot program.

(b) In addition to the preliminary report described in paragraph (a) of this subsection (3), the **STATE** department ~~of health care policy and financing~~ and the department of human services shall submit a final report to the house and senate committees on health, environment, welfare, and institutions no later than January 1, 1997, addressing the following:

(I) **An** assessment of the pilot program costs, estimated cost-savings, benefits to recipients, recipient access to mental health services, and the impact of the program on recipients, providers, and the state mental health system;

(II) Recommendations concerning the feasibility of proceeding with a prepaid capitated system of comprehensive mental health services on a statewide basis;

**(11)** Recommendations resulting from consultation ~~with~~ local consumers, family members of recipients, providers of mental health services, and local human services agencies;

(IV) Recommendations concerning the role of community mental health centers under the prepaid capitated system, including plans to protect the integrity of the state mental health system and to ensure that community mental health providers are not exposed to undue financial risks under the prepaid capitated system. ~~This~~ subparagraph (IV) is based on the unique and historical role that community mental health centers have assumed in meeting the mental health needs of communities throughout the state.

~~(4) (Deleted by amendment, L. 95, p. 917, § 16, effective May 25, 1995.)~~

~~(5)~~ (4) The general assembly finds that preliminary indications from other states show that prepaid capitated systems for providing mental health services to medical assistance recipients result in cost-savings to the state. The general assembly therefore declares it appropriate to amend subsections ~~1, (3), and (4)~~ (1) **AND** (3) of this section and to enact this subsection ~~(5)~~ (4) and subsections ~~(6) to (9)~~ (5) **TO** (8) of this section.

~~(6)~~ (5) On or before **January 1, 1997**, the **STATE** department ~~of health care policy and financing~~ shall seek the necessary waivers to implement the system statewide. **No later than** July 1, 1997, or ninety days after receipt of

the necessary federal waivers, whichever occurs later, the department of human services, in cooperation with the STATE department, ~~of health care policy and financing~~ shall begin to implement on a statewide basis a prepaid capitated system for providing comprehensive mental health services to recipients under the state medical assistance program. The prepaid capitated system shall be fully implemented no later than January 1, 1998, or six months after receipt of the necessary waivers, whichever occurs later. The waiver request shall be consistent with the report submitted to the general assembly in accordance with subsection (3) of this section.

~~(7)~~ (6) The STATE department, ~~of health care policy and financing~~, in cooperation with the department of human services, shall revise the waiver request obtained pursuant to subsection (2) of this section or, if necessary, shall submit a new waiver request that allows the STATE department ~~of health care policy and financing~~ to limit a recipient's freedom of choice with respect to a provider of mental health services and to restrict reimbursements to mental health services providers. **This** waiver request or amendment shall be consolidated with the waiver described in subsection ~~(6)~~ (5) of this section.

~~(8)~~ (7) No later ~~than~~ May 1, 1997, or sixty days after receipt of the necessary federal waivers described in subsections ~~(6) and (7)~~ (5) AND (6) of this section, whichever occurs later, the executive director of the STATE department ~~of health care policy and financing~~ shall propose rules to the medical services board for the implementation of the prepaid capitated single entry point system for mental health services.

~~(9)~~ (8) The implementation of this subsection ~~(9)~~ (8) and subsections ~~(5) to (8)~~ (4) TO (7) of **this** section is conditioned upon the receipt of necessary federal waivers. The implementation of the statewide system shall conform to the provisions of the federal waiver; except that, no later ~~than~~ ninety days after receipt of the federal waivers, the STATE department ~~of health care policy and financing~~ shall submit to the general assembly a report that outlines the provisions of the waiver and makes recommendations for legislation during the next legislative session that assures state conformance to the federal waivers.

**26-4-124. Program of all-inclusive care for the elderly - services - eligibility. [Formerly 26-4-519.]** (1) The general assembly hereby finds and declares that it is the intent of this section to replicate the ON LOK program in San Francisco, California, that has proven to be cost-effective at both the state and federal levels. The PACE program is **part** of a national

replication project authorized in section **9412(b)(2)** of the federal "Omnibus Budget Reconciliation Act of **1986**", as amended, which instructs the secretary of the federal department of health and human services to grant medicare and medicaid waivers to permit not more than ten public or nonprofit private community-based organizations in the country to provide comprehensive health care services on a capitated basis to frail elderly who are at risk of institutionalization. The general assembly finds that, by coordinating an extensive array of medical and nonmedical services, the needs of the participants will be met primarily in an outpatient environment in an adult day health center, in their homes, or in an institutional setting. The general assembly finds that such a service delivery system will enhance the quality of life for the participant and offers the potential to reduce and cap the costs to Colorado of the medical needs of the participants, including hospital and nursing home admissions.

~~(1.5)~~ (2) The general assembly has determined on the recommendation of the state department ~~of health care policy and financing~~ that the PACE program is cost-effective. As a result of such determination and after consultation with the joint budget committee of the general assembly, application has been made to and waivers have been obtained from the federal health care financing administration to implement the PACE program as provided in this section. The general assembly, therefore, authorizes the state department to implement the PACE program in accordance with this section. In connection with the implementation of the program, the state department shall:

(a) Provide a system for reimbursement for services to the PACE program pursuant to this section;

(b) Develop and implement a contract with the nonprofit organization providing the PACE program that sets forth contractual obligations for the PACE program, including but not limited to reporting and monitoring of utilization of services and of the costs of the program as required by the state department;

(c) Acknowledge that it is participating in the national PACE project as initiated by congress;

(d) Be responsible for certifying the eligibility for services of all PACE program participants.

~~(2)~~ (3) The general assembly declares that the purpose of this section is to provide services which ~~THAT~~ would foster the following **goals**:

(a) To maintain eligible persons at home as **an** alternative to long-term institutionalization;

(b) To provide optimum accessibility to various important social **and** health resources that are available to assist eligible persons in maintaining independent living;

(c) **To** provide that eligible persons who are frail elderly but who have the capacity to remain in an independent living situation have access to the appropriate social and health services without which independent living would not be possible;

(d) To coordinate, integrate, and ~~link~~ such social and health services by removing obstacles ~~which~~ **THAT** impede or limit improvements in delivery of these services;

(e) To provide the most efficient and effective use of capitated funds in the delivery of such social and health services;

(f) To assure that capitation payments amount to no more than ninety-five percent of the amount paid under the medicaid fee-for-service structure for an actuarially similar population.

~~(3)~~ (4) Within the context of the **PACE** program, the state department may include any or all of the services listed in sections **26-4-202, 26-4-203, 26-4-302, and 26-4-303**, as applicable.

~~(4)~~ (5) **An** eligible person may elect to receive services' from the **PACE** program **as** described in subsection ~~(3)~~ (4) of this section. If such an election is made, the eligible person shall not remain eligible for services or payment through the regular medicare or medicaid programs. All services provided by said programs shall be provided through the **PACE** program in accordance with this section. **An** eligible person may elect to disenroll from the **PACE** program at any time.

~~(5)~~ (6) **For** purposes of this section, "eligible person" means a frail elderly individual who voluntarily enrolls in the **PACE** program and whose gross income does not exceed three hundred percent of the current federal supplemental security income benefit level, whose resources do not exceed the limit established by the state department of human services for individuals receiving a mandatory **minimum** state supplementation of SSI benefits pursuant to section **26-2-204**, and for whom a physician licensed pursuant **to** article **36** of title **12**, C.R.S., certifies that such a program

provides an appropriate alternative to institutionalized care. The term "frail elderly" means an individual who meets functional eligibility requirements, as established by the state department, for nursing home care and who is sixty-five years of age or older.

~~(6)~~ (7) Using a risk-based financing model, the nonprofit organization providing the PACE program shall assume responsibility for all costs generated by PACE program participants, and it shall create and maintain a risk reserve fund that will cover any cost overages for any participant. The PACE program is responsible for the entire range of services in the consolidated service model, including hospital and nursing home care, according to participant need as determined by the multidisciplinary team. The nonprofit organization providing the PACE program is responsible for the full financial risk at the conclusion of the demonstration period and when permanent waivers from the federal health care financing administration are granted. Specific arrangements of the risk-based financing model shall be adopted and negotiated by the federal health care financing administration, the nonprofit organization providing the PACE program, and the state department.

~~(7) (Deleted by amendment, L. 95, p. 912, § 10, effective May 25, 1995.)~~

(8) Any person who accepts and receives services authorized under this section shall pay to the state department or to an agent or provider designated by the state department an amount that shall be the lesser of such person's gross income minus the current federal aid to needy disabled supplemental security income benefit level and cost of dependents and minus any amounts paid for private health or medical insurance, or the projected cost of services to be rendered to the person under the plan of care. Such amount shall be reviewed and revised as necessary each time the plan of care is reviewed. The state department shall establish a standard amount to be allowed for the costs of dependents. In determining a person's gross income, the state department shall establish, by rule, a deduction schedule to be allowed and applied in the case of any person who has incurred excessive medical expenses or other outstanding liabilities that require payments.

~~(9) (Deleted by amendment, L. 95, p. 912, § 10, effective May 25, 1995.)~~

~~(10)~~ (9) The medical services board shall promulgate such rules and regulations, pursuant to article 4 of title 24, C.R.S., as are necessary to

implement this section.

~~(11)~~ (10) ~~The~~ general assembly shall make appropriations to the state department ~~of health care policy and financing~~ to fund services under this section provided at a monthly capitated rate. The state department ~~of health care policy and financing~~ shall annually renegotiate a monthly capitated rate for the contracted services based on the ninety-five percent of the medicaid fee-for-service costs of ~~an~~ actuarially similar population.

~~(12)~~ (11) The state department may accept grants and donations ~~from~~ private sources for the purpose of implementing this section.

~~(13) (Deleted by amendment, L. 95, p. 912, § 10, effective May 25, 1995.)~~

**26-4-125. Study of certificate program - provider-sponsored organizations.** (1) NO LATER THAN JANUARY 1, **1998**, THE STATE DEPARTMENT SHALL **SUBMIT** TO THE GENERAL ASSEMBLY A LIST OF OPTIONS FOR THE STATE AND THE STATE DEPARTMENT'S RECOMMENDATIONS FOR THE IMPLEMENTATION OF A CONSUMER CERTIFICATE CHOICE PROGRAM. IN CONNECTION WITH THIS SUBMISSION, THE STATE DEPARTMENT SHALL CONSIDER PROCEDURES FOR THE FOLLOWING ACTIVITIES:

(a) SETTING THE **VALUE** OF A CERTIFICATE;

(b) CONTROLLING THE USE OF A CERTIFICATE;

(C) ESTABLISHING A COMPETITIVE BIDDING PROCESS FOR MCO'S AND HEALTH BENEFIT PLANS THAT WILL PARTICIPATE IN A CONSUMER CERTIFICATE CHOICE PROGRAM;

(d) ESTABLISHING WHERE THE **RISK** IS ASSUMED IN THE EVENT THAT A CONSUMER EXHAUSTS THE TOTAL **VALUE** OF A CERTIFICATE ALLOWANCE AND IS STILL IN NEED OF SERVICES;

(e) ASSESSING QUALITY OUTCOMES FOR A CONSUMER CERTIFICATE CHOICE PROGRAM;

(f) COLLECTING DATA AND OUTCOME MEASUREMENTS;

(g) EDUCATING CLIENTS **ABOUT** CHOICE AND USE OF CERTIFICATES.

(2) THE STATE DEPARTMENT SHALL ALSO INCLUDE

RECOMMENDATIONS AS TO INCLUSION OF THE MEDICALLY INDIGENT POPULATION IN THE CONSUMER CERTIFICATE CHOICE PROGRAM. EXPANDED COVERAGE TO IMPOVERISHED COLORADANS SHOULD BE DEVELOPED BASED UPON AN ASSESSMENT OF HOW THE STATE CAN **MAKE** THE MOST EFFICIENT USE OF ALL PUBLIC MONEYS INCLUDING, BUT NOT LIMITED TO, MEDICAID, MEDICALLY INDIGENT, AND DISPROPORTIONATE SHARE FUNDS. THE STATE DEPARTMENT SHALL ALSO EXAMINE ALTERNATIVE SUBSIDY STRUCTURES AND FUNDING RESOURCES FOR THE CONSUMER CERTIFICATE CHOICE PROGRAM.

(3) FOR PURPOSES OF ~~THIS~~ SECTION, "HEALTH BENEFIT PLAN" MEANS ANY HOSPITAL OR MEDICAL EXPENSE POLICY OR CERTIFICATE, HOSPITAL OR MEDICAL SERVICE CORPORATION CONTRACT, OR HEALTH MAINTENANCE ORGANIZATION SUBSCRIBER CONTRACT.

(4) THE STATE DEPARTMENT, IN CONSULTATION WITH THE COMMISSIONER OF INSURANCE, IS ENCOURAGED TO REVIEW THE POTENTIAL FOR MEDICAID SAVINGS THROUGH DIRECT CONTRACTING WITH PROVIDER-SPONSORED ORGANIZATIONS.

**26-4-126 to 26-4-130.** (Reserved)

**SECTION 4. 25.5-1-401,** Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended to read:

**25.5-1-401.** Health care coverage cooperatives - rule-making authority. The executive director may promulgate rules and regulations consistent ~~with~~ the provisions of sections **6-18-204, 6-18-206, 6-18-207, 6-18-207.5,** and **6-18-207.7,** C.R.S., for purposes of carrying out the executive director's duties under said sections. The executive director may promulgate rules and regulations to carry out the executive director's duties under section **6-18-202, C.R.S.** so long as such rules and regulations add no additional requirements other than those specifically enumerated in said section **6-18-202,** C.R.S.; EXCEPT THAT THE EXECUTIVE DIRECTOR MAY ADOPT ADDITIONAL RULES AND REGULATIONS PURSUANT TO SUBPART 2 OF PART 1 OF ARTICLE **4** OF TITLE **26,** C.R.S.

**SECTION 5. 26-4-404 (4) (c),** Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended to read:

**26-4-404.** Providers - payments - rules. (4) (c) The state department shall ensure the following:

~~(I) A managed care provider shall allow a recipient to disenroll at any time;~~

(11) A managed care provider shall establish and implement consumer friendly procedures and instructions for disenrollment and shall have adequate staff to explain issues concerning service delivery and disenrollment procedures to recipients, including staff to address the communications needs and requirements of recipients with disabilities.

(111) All recipients shall be adequately informed about service delivery options available to them consistent with the provisions of this subparagraph (111). If a recipient does not respond to a state department request for selection of a delivery option within forty-five calendar days, the state department shall send a second notification to the recipient. If the recipient does not respond within twenty days of the date of the second notification, the state department shall ensure that the recipient remains with the recipient's primary care physician, regardless of whether said primary care physician is enrolled in a health maintenance organization.

**SECTION 6. 26-4-303 (1) (h),** Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended to read:

**26-4-303. Optional programs with special state provisions.**

(1) ~~This~~ section specifies programs developed by Colorado to increase federal financial participation through selecting optional services or optional eligible groups. These programs include but are not limited to:

(h) The program of all-inclusive care for the elderly, ~~as~~ specified in section ~~26-4-519~~ **26-4-124**;

**SECTION 7. 26-4-404 (1) (b) (II),** Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended to read:

**26-4-404. Providers - payments - rules.** (1) (b) (11) The general assembly shall annually appropriate to the state department of health care policy and financing one-half of the amount that would have been paid to providers if the services described in subparagraph (I) of this paragraph (b) were compensated under both Title XIX and Title XVIII of the social security act, which shall be applied to the ~~costs and expenses of any primary care provider incentive program established as a part of any managed care system established pursuant to section 26-4-104 (2)~~ MAINTENANCE OF A FIXED MARKET RATE PRIMARY CARE PROVIDER INCENTIVE PAYMENT. ~~ANY~~ BALANCE IN THE SAVINGS MAY BE USED TO COVER THE ADMINISTRATIVE

COSTS OF IMPLEMENTING MANAGED CARE PURSUANT TO THE PROVISIONS OF SUBPART 2 OF PART 1 OF ~~THIS~~ ARTICLE AND THE COSTS OF THE EXPANSION OF THE INCENTIVE PROGRAM TO PROVIDERS OF DENTAL SERVICES FOR CHILDREN UNDER THE EARLY PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT PROGRAM.

**SECTION 8.** 26-4-301.3 (1), Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended to read:

**26-4-301.3. Managed care programs - guaranteed minimum enrollment for recipients who become ineligible for benefits - optional program.** (1) Beginning January 1, 1995, any recipient who becomes ineligible to receive benefits under this article ~~and who has been enrolled in a managed care program for less than six months~~ shall continue to be eligible for enrollment in such program for the ~~minimum~~ enrollment period IF THE RECIPIENT:

(a) ~~HAS~~ SELECTED OR BEEN ASSIGNED TO A FEDERALLY QUALIFIED HEALTH MAINTENANCE ORGANIZATION OR PREPAID HEALTH PLAN WITHIN NINETY DAYS OF BECOMING ELIGIBLE FOR MEDICAID; AND

(b) HAS ~~BEEN~~ ENROLLED IN THE MANAGED CARE PROGRAM FOR LESS THAN ~~SIX~~ MONTHS.

**SECTION 9. Repeal of provisions being relocated in this act.** Sections 26-4-519 and 26-4-528, Colorado Revised Statutes, 1989 Repl. Vol., as amended, are repealed.

**SECTION 10. Appropriations in long bill to be adjusted.** For the implementation of this act, appropriations made in the annual general appropriation act for the fiscal year beginning July 1, 1997, to the department of health care policy and financing, shall be adjusted as follows:

(1) The appropriation to medical programs, administration is increased by three hundred thirty-eight thousand five hundred thirty-four dollars (\$338,534), and 4.0 FTE. Of said ~~sum~~, one hundred sixty-nine thousand two hundred sixty-seven dollars (\$169,267) shall be from the general fund and one hundred sixty-nine thousand two hundred sixty-seven dollars (\$169,267) shall be from matching federal funds. Said ~~sum~~ shall be for managed care plan oversight pursuant to section 26-4-113, Colorado Revised Statutes.

(2) The appropriation to medical programs, administration is

increased by one million eighteen thousand one hundred twenty-four dollars (\$1,018,124), and 3.0 FTE. ~~Of~~ said sum, three hundred eighty-five thousand eight hundred sixty dollars (\$385,860) shall be from the general fund and subject to the "(M)" notation as defined in the general appropriation act and six hundred **thirty-two** thousand two hundred sixty-four dollars (\$632,264) shall be ~~from~~ matching federal funds. Said sum shall be for quality assurance and client grievance procedures pursuant to sections 26-4-115, 26-4-116 (1), 26-4-120 (3), and 26-4-117 (1) (b), Colorado Revised Statutes.

(3) The appropriation to medical programs, administration is increased by one million eight hundred eighty thousand eighty-eight dollars (\$1,880,088), and 1.0 FTE. Of said sum, nine hundred forty thousand forty-four dollars (\$940,044) shall be ~~from~~ the general fund and subject to the "(M)" notation as defined in the general appropriation act and nine hundred forty thousand forty-four dollars (\$940,044) shall be from matching federal funds. Said sum shall be for the enrollment broker function pursuant to section 26-4-117 (1) (a) (II), Colorado Revised Statutes.

(4) The appropriation to medical programs, medical services is decreased by two million four hundred seventy-one thousand seven hundred eight dollars (\$2,471,708). Of said sum, one million one hundred eighty-five thousand six hundred seventy-eight dollars (\$1,185,678) shall be from the general fund and one million two hundred eighty-six thousand **thirty** dollars (\$1,286,030) shall be from matching federal funds. Said sum shall be from net savings associated with moving clients into managed care, pursuant to section 26-4-113, Colorado Revised Statutes.

(5) The appropriation to medical programs, other medical services, physician incentive pool is decreased by one million four hundred thirty-one thousand two hundred thirty-six dollars (\$1,431,236). Of said sum, six hundred seventy-eight thousand four hundred forty-three dollars (\$678,443) shall be ~~from~~ the general fund and seven hundred **fifty-two** thousand seven hundred ninety-three dollars (\$752,793) shall be ~~from~~ federal funds. Said sum shall be from savings associated with the movement to a fixed market rate primary care provider incentive payment, pursuant to section 26-4-404 (1) (b) (11), Colorado Revised Statutes.

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**SECTION 11. Safety clause.** The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.

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**Tom Norton**  
**PRESIDENT OF**  
**THE SENATE**

\_\_\_\_\_  
~~Charles E. Berry~~  
**SPEAKER OF THE HOUSE**  
**OF REPRESENTATIVES**

\_\_\_\_\_  
~~Joan M. Albi~~  
**SECRETARY OF**  
**THE SENATE**

\_\_\_\_\_  
**Judith M. Rodrigue**  
**CHIEF CLERK OF THE HOUSE**  
**OF REPRESENTATIVES**

**APPROVED**

\_\_\_\_\_  
~~Roy Roemer~~  
**GOVERNOR OF THE STATE OF COLORADO**

# An Act

SENATE BILL 97-101

BY SENATORS **Rizzuto**, Hernandez, Hopper, Johnson, Linkhart, Martinez, Matsunaka, Pascoe, Phillips, Rupert, Tanner, and **Wham**; also REPRESENTATIVES Grampsas, Allen, Bacon, Mace, Romero, and Snyder.

CONCERNING CONTRACTS TO RECEIVE FEDERAL MATCHING FUNDS FOR AMOUNTS SPENT IN PROVIDING HEALTH SERVICES TO STUDENTS IN PUBLIC SCHOOLS, **AND** MAKING AN APPROPRIATION IN CONNECTION THEREWITH.

*Be it enacted by the General Assembly of the State of Colorado:*

**SECTION 1.** ~~Part 5~~ of article 4 of title 26, Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW SECTION to read:

**26-4-531. Health services - provision by school districts - repeal.**

(1) AS USED IN THIS SECTION:

(a) "EXECUTIVE DIRECTOR" MEANS THE EXECUTIVE DIRECTOR OF THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING.

(b) "SCHOOL DISTRICT" MEANS ANY BOARD OF COOPERATIVE SERVICES ESTABLISHED PURSUANT TO ARTICLE 5 OF TITLE 22, C.R.S., ANY

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Capital letters indicate new material added to existing statutes; dashes **through** words indicate deletions from existing statutes **and** such material not **part** of act.

STATE EDUCATIONAL INSTITUTION THAT SERVES **STUDENTS** IN KINDERGARTEN THROUGH TWELFTH GRADE INCLUDING, BUT NOT LIMITED TO, THE COLORADO SCHOOL FOR THE DEAF AND THE BLIND, CREATED IN ARTICLE **80** OF TITLE **22**, C.R.S., AND ANY PUBLIC SCHOOL DISTRICT ORGANIZED UNDER THE LAWS OF COLORADO, EXCEPT A JUNIOR COLLEGE DISTRICT.

(c) "STATE DEPARTMENT" MEANS THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING.

(d) "UNDERINSURED" MEANS A PERSON WHO HAS SOME HEALTH INSURANCE, BUT WHOSE INSURANCE DOES NOT ADEQUATELY COVER THE TYPES OF HEALTH SERVICES FOR WHICH A SCHOOL DISTRICT MAY RECEIVE FEDERAL MATCHING FUNDS UNDER THIS SECTION:

(2) (a) ANY SCHOOL DISTRICT MAY CONTRACT WITH THE STATE DEPARTMENT UNDER THIS SECTION TO RECEIVE FEDERAL MATCHING FUNDS FOR **AMOUNTS** SPENT IN PROVIDING HEALTH SERVICES THROUGH THE PUBLIC SCHOOLS TO **STUDENTS** WHO ARE RECEIVING MEDICAID BENEFITS PURSUANT TO THIS ARTICLE.

(b) APPROVAL OF CONTRACTS UNDER THIS SECTION DOES NOT CONSTITUTE A COMMITMENT BY THE GENERAL ASSEMBLY TO CONTINUE PROVIDING **HEALTH** SERVICES TO STUDENTS THROUGH THE PUBLIC SCHOOLS USING STATE GENERAL FUNDS IF FEDERAL MATCHING FUNDS ARE NOT AVAILABLE IN THE FUTURE. **ANY** MONEYS PROVIDED TO A SCHOOL DISTRICT PURSUANT TO A CONTRACT ENTERED INTO UNDER THIS SECTION SHALL NOT SUPPLANT STATE OR LOCAL MONEYS PROVIDED TO SCHOOL DISTRICTS PURSUANT TO THE PROVISIONS OF ARTICLES **20** TO **28** OR ARTICLE **54** OF TITLE **22**, C.R.S.

(c) NOTHING IN THIS SECTION SHALL BE CONSTRUED AS REQUIRING ANY SCHOOL DISTRICT TO ENTER INTO A CONTRACT AS PROVIDED IN THIS SECTION. PARTICIPATION IN A CONTRACT BY A SCHOOL DISTRICT IS VOLUNTARY.

(d) THE STATE DEPARTMENT MAY MAKE CONTRACTING AND REIMBURSEMENT OF MONEYS UNDER THIS SECTION CONTINGENT UPON EITHER:

(1) **THE** CONTRACTING SCHOOL DISTRICT CERTIFYING TO THE STATE DEPARTMENT, THROUGH THE DEPARTMENT OF EDUCATION, THAT IT HAS EXPENDED LOCAL AND STATE MONEYS IN AN AMOUNT SUFFICIENT TO MEET

THE NONFEDERAL SHARE OF EXPENDITURES BEING CLAIMED FOR FEDERAL FINANCIAL PARTICIPATION; OR

(II) THE CONTRACTING SCHOOL DISTRICT MEETING THE REQUIREMENTS OF THE INTERGOVERNMENTAL TRANSFER PROVISIONS OF THE FEDERAL MEDICAID LAW, 42 U.S.C. SEC. 1396, ET SEQ.

(3) EACH YEAR, BY A DATE ESTABLISHED BY RULE OF THE MEDICAL SERVICES BOARD, THE DEPARTMENT OF EDUCATION SHALL NOTIFY THE STATE DEPARTMENT CONCERNING ANY SCHOOL DISTRICT THAT CHOOSES TO ENTER INTO A CONTRACT AS PROVIDED IN THIS SECTION AND THE ANTICIPATED LEVEL OF FUNDING FOR THE SCHOOL DISTRICT. NOTHING IN THIS SECTION SHALL BE CONSTRUED TO REQUIRE A SCHOOL DISTRICT TO MAINTAIN THE SAME LEVEL OF FUNDING OR SERVICES FROM YEAR TO YEAR.

(4) (a) (I) EACH SCHOOL DISTRICT THAT CHOOSES TO ENTER INTO A CONTRACT AS PROVIDED IN THIS SECTION SHALL DEVELOP A SERVICES PLAN WITH INPUT FROM THE LOCAL COMMUNITY THAT IDENTIFIES THE TYPES OF HEALTH SERVICES NEEDED BY STUDENTS WITHIN THE SCHOOL DISTRICT AND THE SERVICES IT ANTICIPATES PROVIDING. EXCEPT FOR MEDICAL EMERGENCIES AND SERVICES RELATED TO ALLEGATIONS OF CHILD ABUSE, A STUDENT'S PARTICIPATION IN ANY PSYCHOLOGICAL, BEHAVIORAL, SOCIAL, OR EMOTIONAL SERVICES, INCLUDING COUNSELING OR REFERRALS, SHALL BE OPTIONAL AND SHALL REQUIRE THE PRIOR WRITTEN AND INFORMED CONSENT OF A PARENT OR LEGAL GUARDIAN OF THE STUDENT.

(II) (A) ANY HEALTH QUESTIONNAIRE OR FORM RELATED TO SERVICES FUNDED IN PART THROUGH THIS SECTION SHALL ONLY RELATE TO THE STUDENT'S PERSONAL HEALTH, HABITS, OR CONDUCT AND SHALL NOT INCLUDE QUESTIONS CONCERNING THE HABITS, OR CONDUCT OF ANY OTHER MEMBER OF THE STUDENT'S FAMILY.

(B) NO MEDICAL OR HEALTH DATA OR INFORMATION IDENTIFYING THE STUDENT OR THE STUDENT'S FAMILY SHALL BE DISCLOSED TO ANY PERSON OTHER THAN A PERSON SPECIFICALLY AUTHORIZED TO RECEIVE THE INFORMATION OR DATA WITHOUT THE PRIOR WRITTEN AND INFORMED CONSENT OF A PARENT OR LEGAL GUARDIAN OF THE STUDENT.

(b) EACH SCHOOL DISTRICT THAT CHOOSES TO ENTER INTO A CONTRACT AS PROVIDED IN THIS SECTION SHALL PERFORM AN ASSESSMENT OF THE HEALTH CARE NEEDS OF ITS UNINSURED AND UNDERINSURED STUDENTS AND MAY SPEND AN APPROPRIATE PORTION, NOT TO EXCEED THIRTY PERCENT, OF THE FEDERAL MONEYS RECEIVED ON HEALTH CARE FOR

LOW-INCOME **STUDENTS**. FOR PURPOSES OF **THIS** PARAGRAPH (b), LOW-INCOME STUDENTS MEANS STUDENTS WHOSE FAMILIES **ARE** BELOW ONE HUNDRED EIGHTY-FIVE PERCENT OF THE FEDERAL POVERTY LEVEL.

· (c) **THE** SCHOOL DISTRICT SHALL SUBMIT THE SERVICES PLAN TO THE DEPARTMENT OF EDUCATION WITH A NOTICE OF PARTICIPATION FOR PURPOSES OF TECHNICAL ASSISTANCE EVALUATION AND TO THE EXECUTIVE DIRECTOR FOR APPROVAL.

(5) EACH YEAR NOT LESS THAN NINETY DAYS PRIOR TO THE NOTIFICATION DATE ESTABLISHED PURSUANT TO SUBSECTION (3) OF THIS SECTION, THE STATE DEPARTMENT SHALL PROVIDE INFORMATION THROUGH THE DEPARTMENT OF EDUCATION TO SCHOOL DISTRICTS REGARDING THE AMOUNT OF AVAILABLE MONEYS AND THE ADMINISTRATIVE ACTIVITIES REQUIRED TO ENTER INTO A CONTRACT FOR FEDERAL MATCHING FUNDS FOR THAT YEAR. TO THE EXTENT ALLOWED BY EXISTING RESOURCES, THE DEPARTMENT OF EDUCATION SHALL PROVIDE TECHNICAL ASSISTANCE TO SCHOOL DISTRICTS IN DETERMINING LEVELS OF FUNDING, MEETING ADMINISTRATIVE REQUIREMENTS, AND DEVELOPING SERVICES PLANS.

(6) FOLLOWING THE NOTIFICATION DATE ESTABLISHED PURSUANT TO SUBSECTION (3) OF THIS SECTION, EACH CONTRACTING SCHOOL DISTRICT, THROUGH THE DEPARTMENT OF EDUCATION, SHALL ENTER INTO A CONTRACT WITH THE STATE DEPARTMENT SPECIFYING THE HEALTH SERVICES TO BE PROVIDED BY THE SCHOOL DISTRICT, THE AMOUNT TO BE EXPENDED IN PROVIDING THE SERVICES, AND THE AMOUNT OF FEDERAL MATCHING FUNDS FOR WHICH THE SCHOOL DISTRICT IS ELIGIBLE UNDER THE CONTRACT.

(7) **THE** STATE DEPARTMENT IS AUTHORIZED TO ACCEPT AND EXPEND DONATIONS, CONTRIBUTIONS, GRANTS, INCLUDING FEDERAL MATCHING FUNDS, AND OTHER MONEYS THAT IT MAY RECEIVE TO FINANCE THE COSTS ASSOCIATED WITH IMPLEMENTING THIS SECTION.

(8) (a) UNDER THE CONTRACT ENTERED **INTO** PURSUANT TO THIS SECTION, A CONTRACTING SCHOOL DISTRICT SHALL RECEIVE FROM THE STATE DEPARTMENT ALL OF THE FEDERAL MATCHING FUNDS FOR WHICH IT IS ELIGIBLE UNDER THE CONTRACT, LESS THE AMOUNT OF STATE ADMINISTRATIVE COSTS ALLOWED UNDER PARAGRAPH (b) OF THIS SUBSECTION (8). **ALL** MONEYS RECEIVED BY A SCHOOL DISTRICT PURSUANT TO THIS SECTION SHALL BE USED ONLY TO OFFSET COSTS INCURRED FOR PROVISION OF STUDENT HEALTH SERVICES BY THE SCHOOL DISTRICT OR TO CASH FUND STUDENT HEALTH SERVICES IN THE SCHOOL DISTRICT.

(b) TOTAL ALLOWABLE STATE ADMINISTRATIVE COSTS FOR CONTRACTS ENTERED INTO UNDER THIS SECTION FOR BOTH THE STATE DEPARTMENT AND THE DEPARTMENT OF EDUCATION ARE TWO HUNDRED THOUSAND DOLLARS OR **TWO** PERCENT OF THE TOTAL ANNUAL AMOUNT OF FEDERAL FUNDS ALLOCATED TO THE CONTRACTS FOR THE ENTIRE STATE, WHICHEVER IS GREATER. STATE ADMINISTRATIVE COSTS INCLUDE COSTS INCURRED IN EVALUATING THE IMPLEMENTATION OF THIS SECTION.

(9) THE BOARD OF MEDICAL SERVICES SHALL SPECIFY BY RULE THE TYPES OF HEALTH SERVICES FOR WHICH A SCHOOL DISTRICT MAY RECEIVE FEDERAL MATCHING FUNDS UNDER A CONTRACT CREATED UNDER THIS SECTION, INCLUDING **BUT** NOT LIMITED TO:

(a) BASIC PRIMARY, PHYSICAL, DENTAL, AND MENTAL HEALTH SERVICES;

(b) REHABILITATION SERVICES;

(c) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES; AND

(d) SERVICE COORDINATION, OUTREACH, ENROLLMENT, AND ADMINISTRATIVE SUPPORT.

(10) (a) A SCHOOL DISTRICT THAT PROVIDES HEALTH SERVICES UNDER CONTRACT PURSUANT TO THIS SECTION MAY PROVIDE THE HEALTH SERVICES DIRECTLY OR THROUGH CONTRACTUAL RELATIONSHIPS OR AGREEMENTS WITH PUBLIC OR PRIVATE ENTITIES, AS ALLOWED BY APPLICABLE FEDERAL REGULATIONS. HOWEVER, NO MONEYS SHALL BE EXPENDED IN ANY FORM FOR ABORTIONS, EXCEPT AS PROVIDED IN SECTION **26-4-512** OR AS REQUIRED BY FEDERAL LAW.

(b) WHERE POSSIBLE, THE SCHOOL DISTRICT SHALL COORDINATE THE PROVISION OF **HEALTH** SERVICES TO A STUDENT WITH THE STUDENT'S PRIMARY HEALTH CARE PROVIDER. EXCEPT FOR THOSE SERVICES THAT ARE REQUIRED BY AN INDIVIDUAL, EDUCATIONAL PROGRAM DEVELOPED PURSUANT TO SECTION **22-20-108 (4), C.R.S.**, OR BY A SECTION **504** PLAN DEVELOPED PURSUANT TO THE FEDERAL "REHABILITATION ACT OF **1973**", 29 U.S.C. SEC. **701**, ET SEQ., SCHOOL DISTRICTS SHALL NOT CLAIM REIMBURSEMENT UNDER THIS SECTION FOR DIRECT SERVICES TO STUDENTS ENROLLED IN HEALTH MAINTENANCE ORGANIZATIONS THAT WOULD NORMALLY BE PROVIDED TO STUDENTS BY THEIR HEALTH MAINTENANCE ORGANIZATION.

(11) (a) THE EXECUTIVE DIRECTOR SHALL APPLY FOR AND SECURE ANY FEDERAL WAIVERS AND STATE PLAN AMENDMENTS REQUIRED TO IMPLEMENT THIS SECTION.

(b) THE IMPLEMENTATION OF THIS SECTION IS CONDITIONED UPON WRITTEN APPROVAL OF A STATE MEDICAID PLAN AMENDMENT BY THE FEDERAL HEALTH CARE FINANCING ADMINISTRATION, AND, IF SUCH WRITTEN APPROVAL IS NOT RECEIVED BY THE STATE DEPARTMENT ON OR BEFORE JUNE 30, 1998, THIS SECTION IS REPEALED, AS OF JULY 1, 1998. IN ADDITION, THIS SECTION SHALL REMAIN IN EFFECT ONLY FOR SO LONG AS FEDERAL FINANCIAL PARTICIPATION IS AVAILABLE FOR REIMBURSEMENTS TO SCHOOL DISTRICTS. IN THE EVENT, AS SPECIFIED IN WRITING BY THE ATTORNEY GENERAL TO THE GOVERNOR THAT FEDERAL LAW DOES NOT ALLOW OR IS AMENDED TO DISALLOW REIMBURSEMENTS TO SCHOOL DISTRICTS OR OTHERWISE PREVENT THE IMPLEMENTATION OF THIS SECTION, THIS SECTION IS REPEALED, EFFECTIVE ON THE DATE OF THE ATTORNEY GENERAL'S OPINION.

(12) THE STATE DEPARTMENT **AND** THE DEPARTMENT OF EDUCATION SHALL WORK WITH THE OFFICE OF STATE PLANNING AND BUDGETING AND THE JOINT BUDGET COMMITTEE IN IMPLEMENTING THIS SECTION.

(13) THE STATE DEPARTMENT **AND** THE DEPARTMENT OF EDUCATION SHALL ENTER INTO AN INTERAGENCY AGREEMENT TO PROVIDE FOR THE IMPLEMENTATION OF THIS SECTION. THE MEDICAL SERVICES BOARD AND THE STATE **BOARD** OF EDUCATION ARE AUTHORIZED TO PROMULGATE RULES AS MAY BE NECESSARY IN ACCORDANCE WITH THE AGREEMENT.

(14) THE STATE DEPARTMENT SHALL ANNUALLY, OR MORE OFTEN AS NECESSARY, HOLD A PUBLIC HEARING TO RECEIVE COMMENTS FROM SCHOOL DISTRICTS, STATE AGENCIES, AND INTERESTED PERSONS REGARDING IMPLEMENTATION OF THIS SECTION.

(15) ON OR BEFORE DECEMBER 15, 2002, THE STATE DEPARTMENT SHALL SUBMIT A FORMAL EVALUATION OF THE IMPLEMENTATION OF THIS SECTION TO THE COMMITTEES ON EDUCATION AND THE COMMITTEES ON HEALTH, ENVIRONMENT, WELFARE, AND INSTITUTIONS OF THE HOUSE OF REPRESENTATIVES AND THE SENATE.

**SECTION 2. 26-4-103 (13.5), Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended to read:**

26-4-103. Definitions. As used in this article, unless the context

otherwise requires:

(13.5) "Provider" means any person, public or private institution, agency, or business concern providing medical care, services, or goods authorized under this article and holding, where applicable, a current valid license or certificate to provide such services or to dispense such goods **and** enrolled under the state medical assistance program. These services must be provided and goods must be dispensed only if performed, referred, or ordered by a doctor of medicine or a doctor of osteopathy. Services of dentists, podiatrists, **and** optometrists OR SERVICES PROVIDED BY A SCHOOL DISTRICT UNDER SECTION 26-4-531 need not be referred or ordered by a doctor of medicine or a doctor of osteopathy.

**SECTION 3.** 26-4-203(1), Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW PARAGRAPH to read:

**26-4-203.** Mandated programs with special state provisions. (1) This section specifies programs developed by Colorado to meet federal mandates. ,These programs include but are not limited to:

(f) THE PROGRAM TO PROVIDE HEALTH SERVICES TO STUDENTS BY SCHOOL DISTRICTS AS SPECIFIED IN SECTION 26-4-531.

**SECTION 4.** 26-4-513, Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW SUBSECTION to read:

**26-4-513.** Clinic services. (6) "CLINIC SERVICES" ALSO MEANS PREVENTIVE, DIAGNOSTIC, THERAPEUTIC, REHABILITATIVE, OR PALLIATIVE ITEMS OR SERVICES THAT ARE FURNISHED TO STUDENTS BY A **SCHOOL** DISTRICT, **BOARD OF** COOPERATIVE SERVICES, OR STATE EDUCATIONAL INSTITUTION WITHIN THE SCOPE OF THE "COLORADO MEDICAL ASSISTANCE ACT" PURSUANT TO THE PROVISIONS OF SECTION 26-4-531.

**SECTION 5.** 22-2-112(1), Colorado Revised Statutes, 1995 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW PARAGRAPH to read:

**22-2-112.** Commissioner - duties. (1) Subject to the supervision of the state board, the commissioner has the following duties:

(n) TO ENTER INTO AN INTERAGENCY AGREEMENT WITH THE

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING AND TO PROMULGATE SUCH RULES ~~AND~~ REGULATIONS AS MAY BE NECESSARY UNDER THE AGREEMENT TO ~~ENABLE~~ SCHOOL DISTRICTS, BOARDS OF COOPERATIVE SERVICES, AND STATE EDUCATIONAL INSTITUTIONS TO ENTER INTO CONTRACTS AND TO RECEIVE FEDERAL MATCHING FUNDS FOR MONEYS SPENT IN PROVIDING STUDENT HEALTH SERVICES AS PROVIDED IN SECTION 26-4-513 (6) OR 26-4-531, C.R.S.;

SECTION 6. 22-5-108 (1), Colorado Revised Statutes, 1995 Repl. Vol., is amended BY THE ADDITION OF A NEW PARAGRAPH to read:

**22-5-108. Powers of board of cooperative services. (1)** In addition to any other powers granted by law, the board of cooperative services shall have the following specific powers, to be exercised in its judgment:

(h) TO ENTER INTO CONTRACTS AND TO RECEIVE FEDERAL MATCHING FUNDS FOR MONEYS SPENT IN PROVIDING STUDENT HEALTH SERVICES PURSUANT TO SECTION 26-4-513 (6) OR 26-4-531, C.R.S.

SECTION 7. 22-32-110 (1), Colorado Revised Statutes, 1995 Repl. Vol., is amended BY THE ADDITION OF A NEW PARAGRAPH to read:

**22-32-110. Board of education - specific powers. (1)** In addition to any other power granted to a board of education of a school district by law, each board of education of a school district shall have the following specific powers, to be exercised in its judgment:

(ii) TO ENTER INTO CONTRACTS AND TO RECEIVE FEDERAL MATCHING FUNDS FOR MONEYS SPENT IN PROVIDING STUDENT HEALTH SERVICES PURSUANT TO SECTION 26-4-513 (6) OR 26-4-531, C.R.S.

SECTION 8. 22-80-103, Colorado Revised Statutes, 1995 Repl. Vol., is amended to read:

**22-80-103. Name - powers. (1)** Such institution is a body corporate under the name of Colorado school for the deaf and the blind and may sue and be sued and may take and hold real estate by gift, devise, or otherwise for the use and benefit of such school.

(2) THE INSTITUTION MAY ENTER INTO CONTRACTS AND RECEIVE FEDERAL MATCHING FUNDS FOR MONEYS SPENT IN PROVIDING STUDENT HEALTH SERVICES AS PROVIDED IN SECTION 26-4-513 (6) OR 26-4-531,

C.R.S.

**SECTION 9. Repeal.** Article 82 of title 22, Colorado Revised Statutes, 1995 Repl. Vol., as amended, is repealed.

**SECTION 10. Appropriation.** "(1) In addition to any other appropriation, there is hereby appropriated, to the department of health care policy and financing, medical services, other medical programs, for the fiscal year beginning July 1, 1997, the sum of seventeen million eight hundred fifty-four thousand three hundred twenty-six dollars (\$17,854,326) and 2.0 FTE, or so much thereof as may be necessary for the implementation of this act. Of said sum, eight million five hundred sixty-four thousand seven hundred twenty dollars (\$8,564,720) shall be from moneys provided by school districts and nine million two hundred eighty-nine thousand six hundred six dollars (\$9,289,606) shall be from matching federal funds. Of the federal funds appropriated, ninety thousand two hundred eighty-eight dollars (\$90,288), or so much thereof as may be necessary for the implementation of this act, shall be for the department's administrative expenses.

(2) In addition to any other appropriation, there is hereby appropriated, to the department of education, school district and library assistance, for the fiscal year beginning July 1, 1997, the sum of ninety-nine thousand three hundred ninety-nine dollars (\$99,399), or so much thereof as may be necessary for the implementation of this act. Said sum shall be from a cash funds exempt transfer made from the department of health care policy and financing-out of the federal funds appropriation made in subsection (1) of this section and pursuant to the interagency agreement developed pursuant to section 26-4-531 (13), Colorado Revised Statutes.

(3) In addition to any other appropriation, there is hereby appropriated, to the department of education, distributions, for the fiscal year beginning July 1, 1997, the sum of nine million ninety-nine thousand nine hundred nineteen dollars (\$9,099,919), or so much thereof as may be necessary for the implementation of this act. Said sum shall be from a cash funds exempt transfer made from the department of health care policy and financing out of the federal funds appropriation made in subsection (1) of this section and pursuant to the interagency agreement developed pursuant to section 26-4-531 (13), Colorado Revised Statutes.

**SECTION 11. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.**

Tom Norton  
**PRESIDENT OF  
THE SENATE**

~~Charles E. Berry~~  
**SPEAKER OF THE HOUSE  
OF REPRESENTATIVES**

~~John M. Albi~~  
**SECRETARY OF  
THE SENATE**

~~Judith M. Rodrigue~~  
**CHIEF CLERK OF THE HOUSE  
OF REPRESENTATIVES**

**APPROVED**

~~Roy Romer~~  
**GOVERNOR OF THE STATE OF COLORADO**